

# **Speech & Language Guidelines for Determining Evaluation, Eligibility, & Level of Service**

Ionia County ISD  
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(Adapted from Kent ISD)

**SPEECH & LANGUAGE GUIDELINES COMMITTEE**

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### Introduction & Purpose

The purpose of this document is to provide a set of guidelines and criteria for the determination of eligibility for students exhibiting *Speech and/or Language Impairments* in the Ionia County Intermediate School District. These guidelines are based on the following: the *Michigan Revised Administrative Rules for Special Education (April, 2009)*, the *Individuals with Disabilities Education Improvement Act of 2004*, the *Michigan Speech-Language-Hearing Association (MSHA, 2006)*, and the *Kent ISD Speech & Language Evaluation, Eligibility, and Services Guidelines (2008)*.

This document serves to assist intervention teams in clarifying procedural and eligibility issues in order to assure compliance with current special education laws, consistency among school districts within the county, and the implementation of current “best” practices.

## Federal & State Regulations & Guidelines

The *Individuals with Disabilities Education Improvement Act (IDEA) of 2004* provides the process required in the identification of students with **Speech-Language Impairments**. In general, as part of an initial evaluation, IDEA 2004 Section 614 states:

(A) A State educational agency, other State agency, or local educational agency shall conduct a full and individual initial evaluation in accordance with this paragraph and subsection (b), before the initial provision of special education and related services to a child with a disability under this part.

(i) Such initial evaluations shall consist of procedures –

(I) to determine whether a child is a "child with a disability" (as defined in section 602); **and**

(II) to determine the educational needs of such child.

To be eligible as a "student with a disability", IDEA 2004 Section 602 and the State Administrative Rules for Special Education (April 2009, R 340.1702) state the IEP team must establish the following:

1. Results of the evaluation indicate that the student meets the specified criteria for an impairment in 1 or more areas of impairment identified in the Act (in this case, a Speech-Language Impairment), **and**
2. As a result of the identified impairment, the student **needs** special education and related services.

### Definition of Speech & Language Impairment (SLI)

The Michigan Administrative Rules for Special Education (April, 2009) provides the following definition of Speech & Language Impairment.

#### **"Speech & Language Impairment" defined; determination.** [R 340.1710 ]

- (1) A "speech and language impairment" means a communication disorder that adversely affects educational performance, such as a language impairment, articulation impairment, fluency impairment, or voice impairment.
- (2) A communication disorder shall be determined through the manifestation of 1 or more of the following speech and language impairments that adversely affects educational performance:
  - (a) A language impairment which interferes with the student's ability to understand and use language effectively and which includes 1 or more of the following:
    - i. Phonology.
    - ii. Morphology.
    - iii. Syntax.
    - iv. Semantics.
    - v. Pragmatics.
  - (b) Articulation impairment, including omissions, substitutions, or distortions of sound, persisting beyond the age at which maturation alone

- might be expected to correct the deviation.
- (c) Fluency impairment, including an abnormal rate of speaking, speech interruptions, and repetition of sounds, words, phrases, or sentences, that interferes with effective communication.
  - (d) Voice impairment, including inappropriate pitch, loudness, or voice quality.
- (3) Any impairment under subrule (2)(a) of this rule shall be evidenced by both of the following:
- (a) A spontaneous language sample demonstrating inadequate language functioning.
  - (b) Test results on not less than 2 standardized assessment instruments or 2 subtests designed to determine language functioning which indicate inappropriate language functioning for the student's age.
- (4) A student who has a communication disorder, but whose primary disability is other than speech and language may be eligible for speech and language services under R340.1745(a).
- (5) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, which shall include a teacher of students with speech and language impairment under R 340.1796 or a speech and language pathologist qualified under R 340.1792.

### **Definition of Speech & Language Impairment (SLI) Services**

The Michigan Administrative Rules for Special Education (April, 2009) provides the following definition of Speech & Language Service:

### **Definition of "Services for students with speech and language impairment." [R340.1745]**

All of the following provisions are specific requirements for speech and language services:

- (a) The speech and language services provided by an authorized provider of speech and language services shall be based on the needs of a student with a disability as determined by the individualized education program team after reviewing a diagnostic report provided by an authorized provider of speech and language services.
- (b) The determination of caseload size for an authorized provider of speech and language services shall be made by the authorized provider of speech and language services in cooperation with the district director of special education, or his or her designee, and the building principal or principals of the school or schools in which the students are enrolled. Caseload size shall be based upon the severity and multiplicity of the disabilities and the extent of the service defined in the collective individualized education programs of the students to be served, allowing time for all of the following:
  - (i) Diagnostics.
  - (ii) Report writing.
  - (iii) Consulting with parents and teachers.

- (iv) Individualized education program team meetings.
- (v) Travel.
- (c) Individual caseloads of authorized providers of speech and language services shall not exceed 60 different persons and shall be adjusted based on factors identified in subdivision (b) of this rule. Students being evaluated shall be counted as part of the caseload.
- (d) An authorized provider of speech and language impaired services shall be either a teacher of students with speech and language impairment under R 340.1781, R 340.1782, and R 340.1796, or a person with a master's degree, as qualified under R340.1792.

### **The Need for Special Education Services**

As part of the evaluation requirements, in addition to meeting the eligibility requirements as cited above, the IEP team must determine whether the child **needs** special education and related services. The IEP team has the responsibility to document whether or not the need for special education service exists.

Interventions in general education, which may include special or supplemental materials, modification of instructional techniques, or other support services provided within the general education environment, may suffice to meet the student's needs. This could also include accommodations made under Section 504 of the Civil Rights Act, 1973.

A child may have a medical diagnosis and not qualify for special education. A child will be eligible as a SLI student only if the speech and/or language impairment adversely affects his/her educational performance. A child whose speech and/or language impairment does not interfere with his/her day-to-day functioning within the educational setting would not be eligible for special education services.

The continuum of impairment depends on the level of severity. A student with a mild impairment would likely require no special education services. A student with a mild to moderate impairment may require some adaptation or modification in the school setting. A student with a moderate to severe impairment may require a more restrictive environment.

To preserve the child's right to a Free Appropriate Public Education (FAPE), accommodations may be made under section 504 of the Civil Rights Act of 1973. Not all students with speech and/or language impairments experience learning problems, nor do they require special education and related services. Only when the accommodations are beyond what is required under Section 504, should eligibility for special education be considered. (See Appendix A for a comparison of Section 504 and IDEA.)

### **Redetermination of Eligibility**

Redetermination of eligibility will be established in the same manner as for initial evaluations. Some students upon reevaluation may be found ineligible for special education

programming as Speech & Language Impaired. This may occur when the conditions have stabilized such that the student no longer requires special education and/or accommodations, including assistive technology. This may also occur if the student has acclimated and developed strategies to be successful within the general education curriculum. While the student may be ineligible for special education programming, accommodations may still be necessary under Section 504 or the Americans with Disabilities Act.

### **Reevaluations**

In general, as part of any reevaluation, IDEA 2004 §300.533 states that the IEP team and other qualified professionals as appropriate shall –

- (1) Review existing evaluation data [REED] on the child, including—
  - (i) Evaluations and information provided by the parents of the child;
  - (ii) Current classroom-based assessments and observations; **and**
  - (iii) Observations by teachers and related services providers; **and**
- (2) On the basis of that review, and input from the child's parents, identify what additional data, if any, are needed to determine -
  - (i) Whether the child continues to have a disability;
  - (ii) The present levels of performance and educational needs of the child;
  - (iii) Whether the child continues to need special education and related services; **and**
  - (iv) Whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the IEP of the child and to participate, as appropriate, in the general curriculum.

Furthermore, if the IEP team, and other qualified professionals as appropriate, determines that no additional data are needed to determine whether the child continues to be a child with a disability, the school district shall –

- (1) Notify the child's parents—
  - (i) Of the determination and the reasons for it; **and**
  - (ii) Of the right of the parents to request an assessment to determine whether the child continues to be a child with a disability; **and**
- (2) Not be required to conduct the assessment unless requested to do so by the child's parents.

## Michigan Speech-Language-Hearing Association Guidelines

The *MSHA Guidelines* (2006) are an excellent resource for speech-language pathologists (SLPs). There are, nonetheless, several significant issues that concern SLPs working in the school setting which require further clarification by local districts. These are identified in the *MSHA Guidelines* document and include:

- Documenting indirect workload activities and scheduling of services (p. WC-7).
- Early intervening process (p. PL-2) and notification and permission of parents for early intervention (pp. L-9,F-6, V-4).
- Determining the presence of a speech and language disorder using multiple assessments, test selection guidelines, and score comparison guidelines (pp. SLI-4-6, L-27).
- Dual certification and related service (pp. SLRS-2-3, LD-12).
- When to certify a student as learning disabled in oral expression and/or listening comprehension rather than SLI (p. LD-18).
- How to document assistive technology needs in the IEP (pp. AT-8-9).
- Dismissal criteria (pp. SLI-9-10, SLRS-5).

Staskowski (2007) and Ehren (2007) in separate presentations have emphasized the changing role of SLPs as a result of changes in laws and the needs of students. Language is the foundation of literacy and SLPs are the experts in language. The role of the SLP needs to be different, not more of the same. Staskowski and Ehren have emphasized the unique contribution that SLPs can make as members of educational teams.

The ICISD guidelines are based off of Kent ISD's guidelines which were developed as a direct response to the *MSHA Guidelines* (2006).

## Pre-referral Procedures

The *Individuals with Disabilities Education Improvement Act 2004 (IDEA)* encourages the adoption of pre-referral interventions prior to placement in special education. Local school districts are strongly encouraged to establish district procedures to implement pre-referral strategies and interventions of all students experiencing academic and behavioral difficulties.

Documentation of pre-referral strategies is an important component in determining the need for special education. This also applies to a student with a speech-language impairment. It is recommended that a building-level professional support team, such as an Instructional Consultation Team (ICT), be utilized to ascertain the child's educational strengths, difficulties and needs, and to develop alternatives and strategies to meet those needs within the education milieu. All interventions should be in place and well documented over a reasonable period of time, within a minimum of six to nine weeks (see *Request for Speech & Language Screening* form, Appendix B. See also Appendices C & E). The support team should seek not to deny special education services, but to guarantee that appropriate interventions have been attempted before further determination is made about the existence of a disability.

The development and implementation of appropriate pre-referral interventions in many cases will eliminate the need to refer the student for further special education evaluation. Such interventions devised to meet the individual student's need, will assure that the student's rights to a Free Appropriate Public Education (FAPE) is upheld.

It is suggested that the building-level professional support team where ICT is not available include:

- a. The student's general education teacher(s),
- b. A special education teacher with knowledge of alternative instructional techniques and strategies,
- c. A speech-language pathologist, and
- d. A building administrator.
- e. Additional team members may vary depending upon the needs of the child.

The team should gather information about a student from a variety of sources in order to develop the most effective pre-referral interventions. These may include the student's cumulative file, work samples, teacher observations and records, report cards, parental input, medical information and physician reports, and other information relevant to the student's learning.

The building-level professional support team has the responsibility of documenting the pre-referral intervention strategies attempted over a reasonable period of time. If the team then concludes that there may still be a need for special education intervention, a Review of Existing Evaluation Data (REED, see Appendix F) form should be completed.

## ICISD Guidelines for SLI Evaluations

### Considerations for the REED Team

Once a request for an SLI evaluation is made, a REED should be completed. Input **must** be provided by the following:

- Parent (s);
- General education teacher (s);
- Speech Therapist;
- Other persons with relevant knowledge of the student or the condition.

As part of the REED process, the team shall review existing prereferral intervention data, information provided by the parents, current classroom-based assessments and observations, and information provided by medical personnel (when appropriate).

On the basis of that review, the team will identify what additional data, if any, is needed. This may include:

- Developmental history;
- Cognitive tests;
- Achievement tests;
- Report cards;
- Attendance records;
- Behavior rating scales;
- Systematic observations.

### Initial SLI evaluations

The SLI MET Chairperson (Speech-Language Pathologist) will be responsible for the following:

1. Collecting input and documentation from those who have worked with or observed the student and include it with the REED form (see *MSHA Guidelines 2006* for Teacher, Parent, Student Input forms included in *Optional Tools* section of these guidelines).
2. Collecting documentation/evidence of the interventions, strategies, and ICT process which have been in place for the student.
3. Indicating academic assessments, observations and evaluations for related services as appropriate.

### Reevaluations for SLI

The SLI MET Chairperson (Speech-Language Pathologist) will be responsible for the following:

1. The initiation of a reevaluation plan for an SLI student which is open to design for the specific needs of the student.
2. Considering and collecting assessments to determine the continued need for

## ICISD Guidelines for Evaluation

special education or to determine present levels of performance as needed. If the team feels they do not need any additional information, all assessments may be waived.

## PART 1: CRITICAL ISSUES

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## EARLY INTERVENING SERVICES USING RESEARCH-BASED CURRICULUM INTERVENTIONS

The concept of early intervening services for school-age students comes from IDEA 2004. The intent is to provide preventative services to children who have not been identified as needing special education and related services but may be experiencing some problems. Early intervening services are designed to address grades K-12 with an emphasis on grades K-3. The most commonly used model is called “Response to Intervention” (RtI). For the purposes of this document, research-based curriculum interventions will be referred to as RtI or early intervening services. RtI in Ionia County may also be referred to as Instructional Consultation (IC).

The core principles of this integrated, research-based approach, aimed at enhancing educational outcomes for all children, include:

- Early identification of students not achieving at benchmark
- High-quality instruction and interventions matched to student need (such as trial intervention for speech and language)
- Frequent monitoring of student progress to make decisions about instruction or goals
- Use of child response data to make educational decisions, including professional development, curriculum, and individual intervention decisions. (MAASE, 2007)

### **Position Statement**

Ionia ISD supports the position of the American Speech-Language-Hearing Association that:

*“speech-language pathologists play a critical and direct role in the development of literacy for children and adolescents with communication disorders, including those with severe or multiple disabilities. Speech language pathologists also make a contribution to the literacy efforts of a school district or community on behalf of other children and adolescents. These roles are implemented in collaboration with others who have expertise in the development of written language and vary with settings and experience of those involved.” (ASHA, 2001)*

## EVALUATION

The *Federal Register* (v. 71, no. 156, August 14, 2006) contains regulations implementing changes necessitated by the reauthorization of IDEA (2004). The evaluation of children with disabilities is addressed in §300.122 . It states that they must be evaluated in accordance with §§300.300 through 300.311 of subpart D of part II. These sections include legal requirements for parental consent (§300.300), screening for instructional purpose which is not for evaluation (§300.302), evaluation procedures (§300.304), additional requirements for evaluations and reevaluations (§300.305), and the determination of eligibility (§300.306). *Michigan Revised Administrative Rules for Special Education (2009)* also addresses these requirements in Rules 340.1710, 340.1721, and 340.1745.

### Screening and Observation

**General Screening** – Screening across general populations for instructional purpose (such as “Kindergarten round-up”) is not an evaluation . Instructional purpose means determining appropriate instructional strategies for curriculum implementation. This type of screening does not require parental permission when the test or other evaluation tool is administered to all students, unless consent is required from all parents (see *Optional Tools* section of these guidelines for screening tools).

**Consultation and Observation by Special Education Staff** – In general, state policy limits prereferral consultation to direct interaction with general education personnel or student observation. It excludes direct interaction with general education students not in referral. Activities conducted outside of these procedures are considered general education, and outside of the scope of special education funded staff.

**Individual Screening** – Screening includes brief, limited contact with a student by special education staff with the intent to help a building team decide if a special education referral is appropriate. Written parental consent should be obtained prior to any individualized screening contact with a student (see Appendices B, C, & E). It is important that such individual screening remains limited to a brief probe that does not rise to the level of activities typical of a special education evaluation. If it is felt that evaluation is needed, a formal referral and parent consent should be initiated prior to a special education evaluation (see below).

**Early Intervening Services** –The intent of these services is to prevent special education referrals by implementation of tiered general and special education intervention for children not identified as needing special education but who may be experiencing problems in one or more areas of achievement such as reading.

### Referral

A concern may develop into a formal referral when the *Review of Existing Evaluation Data (REED)* form is signed by the parent or guardian and is received by the local dis-

district administration. The 30-school-day timeline for completion and IEP imposed by the State of Michigan begins when the referral is actually received by the district [R. 340.1721c(2)]. If the student already qualifies for special education then the completion date is noted on the *REED* form. If a date for completion is not noted for a reevaluation, it is assumed to be 30 school days from the date the parent's signature/consent is received by the district.

If the referral is an Initial, then a copy of the *Special Education Parent Handbook with Procedural Safeguards* must be provided to the parent/guardian. In the case of a student who is already eligible for special education, then a copy of the *Procedural Safeguards* must be offered to the parent/guardian at every IEP.

School personnel may receive a written statement from a parent or guardian requesting an "evaluation" or "testing." A written request is not the start of the formal evaluation with a 30-school-day timeline. However, it does start a process that requires a written response. Within ten days of receiving a written request from either the parent/guardian and/or the IC Team for an evaluation, the parent must be notified using a *Prior Written Notice of Initial Referral* sample letter which should be sent home by the special education director of the district (see Appendix E) [R340.1721(1)].

Best practice indicates the local district should take an immediate proactive response and contact the person requesting the evaluation. The district representative should determine why the evaluation is sought and the nature of the evaluation. This information is required as part of R340.1721(1)(a). At this time the educator making the contact should respond to concerns and explain the process. Depending on the specific situation, the process might range from taking the concerns to the building's ICT or child study team/student study team for intervention to immediately preparing the paperwork for parental signature to start a formal evaluation. Ideally, a face-to-face meeting is best since communication may be better and timelines for referral notices and evaluation consents or written withdrawals of request can be taken care of at one time.

It is important all parties understand that no student can qualify for special education under IDEA (2004) unless it can be documented that prior to the referral research-based interventions within the general education classroom have been provided and have been unsuccessful [§300.306(b)]. These interventions are usually recommended and monitored as part of a general education building team process, such as Instructional Consultation (IC).

All communication and responses should be documented. If the parent decides to withdraw a written request for an evaluation, that withdrawal must be in writing. When this happens the withdrawal is often contingent upon some other action and possible reconsideration of a referral later, which should also be in writing. If any parental communication is oral, school personnel should still document the verbal exchange in writing.

### **General Procedures for Evaluation**

A special education evaluation includes the use of a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child, including information provided by the parent. Reevaluations require review of existing evaluation data (REED) from the school and any data that may be provided by the parents; observations by teachers and related service providers; formal testing; and documentation of the need for special education services. An evaluation report must be provided in writing to the IEP Team including the parents for determination of eligibility and needed services.

A reevaluation requires a *REED* form. The *REED* form documents a review of the information available and any additional information needed to determine if a student continues to have a disability and whether the child continues to need special education services.

### **General Education Intervention Information**

Documentation from early intervening services using research-based curriculum interventions must be included as part of an evaluation. No student can qualify for special education services under IDEA regulations and/or Michigan rules without documentation of a special education evaluation. The term “prereferral process” should not be used as it too often implies a pre-emptive decision about initiating a special education referral. There should be differentiated general education services available to all students with the goal of students benefiting appropriately from such services. A student cannot be determined as having a disability if the student has not been provided appropriate academic instruction or has limited English proficiency. Early intervening services are used to determine if appropriate instruction has been provided to meet the student’s needs and assist in documenting the need for specially designed instruction available only through special education. This is particularly important when working with ELL students (see the ELL section of this document). The lack of benefit and success in the general education curriculum even after research-based curriculum interventions have been tried indicates a need for a special education evaluation. Special education eligibility is discussed in the next section.

**Trial Intervention Steps**—As part of Rtl, and in effort to maximize the child’s general education resources/supports, trial intervention is recommended. The following is the protocol to utilize:

1. When a child is brought to your attention with suspected speech/language concerns, need to collect data (file review, teacher input, parent input, observation);
2. Based on the data, if any concerns, teacher completes *Request for Speech & Language Screening Form* (see Appendices B, C, & E)
  - a. Send memo along with form home to parent to get consent for screening and trial intervention (see Appendix C for sample letter);
3. Upon receipt of signed consent, screen/collect base-line data;

4. Notify parent and teacher of results;
  - a. If no concerns, then no need for intervention.
  - b. If concerns are noted, then proceed to performing up to nine weeks of trial intervention(s) (add: *See **Optional Tools** for suggested interventions—based on flowchart from “perform up to 9 weeks of trial intervention” from G. Findlay*)
5. Collect pre-, during-, and post-data.
  - a. If problem is resolved, then discontinue service.
  - b. If good progress is noted and full evaluation is not warranted or the student is not stimulable for articulation errors, then provide a home and/or classroom program. Rescreen within six months.
  - c. If minimal to no progress and/or more concerns are discovered, then SLP needs to follow the *Formal Special Education Process* as described in the following sections.

## **The Formal Special Education Process: Evaluation Review/Consent**

**Prior Written Notice of Referral for Special Education**—When concerns for a student’s academic achievement and functional performance persist after interventions in general education, a special education referral may be warranted. At which point, the district has 10 calendar days to notify the parent/guardian in writing (see *Prior Written Notice of Initial Referral for Special Education* sample letter to parent, Appendix E). The team then completes the REED form to review all of the pertinent data collected and then obtains parent/guardian signatures for consent to evaluate. Gathering information from teachers, parents and students is an important aspect of the evaluation process. This information may be gathered through a variety of checklists provided by the 2006 *MSHA Guidelines* on pages A-11 through 13 respectively.

### **Evaluation Requirements**

An evaluation to determine eligibility for special education as a student with a speech and language impairment **must** include the following information and documentation:

- Ability/achievement/developmental level,
- Relevant behavior observations,
- Speech/language level,
- Spontaneous language sample,
- Educationally relevant medical information (if any), **and**
- Information from parents.

### **Use of Tests**

Tests are used to aid in determining ability/achievement/developmental level and the student’s speech/language level. There are two types of tests: standardized and non-standardized. Both play an important role in the evaluation procedure.

**Standardized Tests** are required as part of the evaluation if available for the area of

concern. These tests cannot be the sole factor for determining eligibility, but aid in obtaining information on levels of:

- Ability;
- Achievement;
- Development;
- Speech;
- Language.

**Nonstandardized Tests** and assessment procedures may and should be used to support and expand on standardized test results. They are useful in determining both strengths and weaknesses but cannot be used without standardized tests for determining eligibility. They aid in developing interventions, goals and objectives, and documenting progress over time. Nonstandardized tests and assessment procedures include:

- Curriculum-Based Assessment (see MSHA, p. L-19);
- Criterion referenced tests;
- Standardized tests administered using nonstandard procedures;
- Developmental scales;
- Checklists;
- Dynamic assessments (test-teach-retest);
- Play-based assessment;
- Speech intelligibility measures [see Bowen, C. (2006). Speech Intelligibility from 12 to 48 months. Retrieved from [www.speech-language-therapy.com/intelligibility.htm](http://www.speech-language-therapy.com/intelligibility.htm) on (6-29-10)];
- Review of student records;
- Spontaneous language samples

Any test or evaluation material must comply with §300.304(c)(1). Each public agency must insure that assessments and other evaluation materials:

- i. are selected and administered so as not to be discriminatory or racially biased;
- ii. are provided and administered in the child's native language;
- iii. are used for the purposes for which the assessments or measures are valid and reliable;
- iv. are administered by trained and knowledgeable personnel; and
- v. are administered in accordance with any instructions provided by the producers of the assessments.

Additionally, ethical standards outlined in *Standards for Educational and Psychological Testing* (AERA, APA & NCME, 1999) need to be met. Anyone administering tests should be familiar with this publication.

Each test should have an accompanying manual. It should contain enough information to determine the appropriate use of the test and interpretation of scores obtained. Information and data on the normative sample, reliability, and validity should be provided.

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The *normative sample* is the population with which the test was normed. In order to apply the test norms to the larger population the sample should:

- Represent the most recent census,
- Be large enough to insure reliability and validity,
- Be representative of the student to be tested in terms of racial-ethnic and geographic status and disability.

**Reliability** refers to the consistency of scores over time/freedom from measurement error. There are several types of reliability, each determined using statistical procedures. Test-retest reliability is generally looked at as the best indicator of a test's reliability. This is determined by administering the same test to the same group after a period of time and correlating the scores.

**Validity** tries to answer the question, "Does the test measure what it purports to measure?" Validity cannot be measured like reliability. It is inferred using a variety of methods including accumulated evidence and theory supporting specific interpretations of the test.

Language is complex and difficult to measure, thus language tests tend to be less reliable and valid than is desirable. Each test should be considered by the standards set for that test to be a valid method of identification. A general rule is that a test-retest reliability of .9 or higher is best; .8 to .9 is okay; and less than .8 is unsuitable. For this topic a close reading of the *MSHA Guidelines* at pages SLI-1 through SLI-11 is strongly suggested.

### **Sensitivity and Specificity**

ASHA and MSHA stress the importance of sensitivity and specificity for a test (.80 or better). If the test does not have acceptable levels of sensitivity and specificity, then one needs go no further in reviewing the acceptability of other psychometric standards such as population sample, reliability, and validity (Spaulding, Plante & Farenella, 2006). Sensitivity and specificity are terms that are not as familiar as validity and reliability to speech-language pathologists and others.

- **Sensitivity** refers to the degree to which a test correctly identifies a language impaired student as language impaired.
- **Specificity** refers to the degree to which a test correctly identifies a non-language impaired student as nonlanguage impaired.

As the importance of these measures has become apparent, more publishers are including this information in their test manuals. This data is also becoming more available in the research literature.

### **Interpretation of Test Scores**

Test scores are only one factor in determining eligibility. Based on input from other disciplines, internet research, various test manuals, county data, and professional discussion, it is the opinion of this committee that 1.5 deviations below the mean (standard score of 78;  $x=100$ ;  $SD=15$ ) should be used as a general guideline for determining eligibility. Test scores are just one piece of information that must be considered with other types of information when assessing the impact of a suspected disability. This committee will continue to research this topic and provide updated information as it becomes available. (For further examples see *Optional Tools* section.)

Consult the administration manual for each test for technical subtest data. A comprehensive list of tests most commonly used in Ionia County ISD is provided in *Optional Tools* section. Caution is advised when looking at subtest scores. They are generally less reliable than total test scores. Sensitivity and specificity are also different for subtests than they are for total tests, but data for total tests are all that are usually provided in the manuals.

This does not imply that there is no use for subtests. They play an important role in the total evaluation as noted above. Their usefulness includes identifying weaknesses in need of remediation, providing guidance in determining goals and objectives, and documenting progress over time.

### **Cognitive Referencing**

The term “cognitive referencing” has been used frequently in the speech-language literature. *MSHA Guidelines* (2006) call cognitive referencing the practice of comparing a student’s language performance to their performance on cognitive measures. “Severe discrepancy” refers to the degree of discrepancy between a standardized ability test and a standardized achievement test and is a term more frequently used by school psychologists for the same concept. The consensus is that neither cognitive referencing nor severe discrepancy should be used as the **sole** determining factor in determining special education eligibility. Legally, there should never be any one determinate for eligibility, such as a language-cognitive ability discrepancy or any other single factor. As noted above, an evaluation consists of much more than one or two test scores.

There are times when the concept of cognitive referencing is useful and aids in the comprehensive evaluation. For example, in *Speech-Language Guidelines for Schools*, the Kansas State Department of Education (2005) endorses the use of a severe discrepancy between the performance of the student and his or her peer, or evidence of a severe discrepancy between the student’s ability and performance in the area(s) of concern as part of the procedure for determining eligibility for special education speech and language services. This is not the sole criterion; it is part of the entire evaluation process. The severe discrepancy determination is made by examining interventions, school records, interviews, observations, and assessments, not just by comparing one test score to another.

Looking at a discrepancy using the Kansas method can be useful in determining reasonable language expectations. It helps in understanding the whole child. Is the student's speech-language performance within an expected range for that student based on the multiplicity of available information? A psychoeducational evaluation by the school psychologist may be needed when working with complex cases. The psychologist's input may help in determining reasonable language expectations. His/her evaluation may impact eligibility, type of service needed, service provider, and dismissal of services. Extreme caution should be used when considering reasonable language expectations for a very young child.

### **Informed Clinical Opinion**

Although this term has been used and applied primarily to the birth to 36-month age group and is referred to in law (IDEA, Part C) the concept seems applicable across the spectrum. No one procedure, test, battery of tests, checklist, or observation alone is valid, reliable, or legal for special education identification. Professionals gathering various forms of data regarding a student must always interpret the data and include information from parents and others, then synthesize that information as a member of a team. There is less formal documented information available for younger children. As a student gets older there is more information such as standardized test scores, school records, and research-based early intervention data, and thus there is more concrete information on which to base an informed decision.

Final decisions regarding special education eligibility have generally included some degree of "professional opinion" or "professional judgment." Basing this part of the evaluation on information versus simple opinion is really making an informed clinical opinion (Schackelford, 2002; Bagnato, Smith-Jones, Matesa & McKeating-Esterle, 2006). ASHA (2003) also discusses the role of professional judgment based on documentation. The term "informed clinical opinion" reflects how each professional and each team should interpret the data and information collected during the evaluation. Informed clinical opinion will be the term used in this document.

## ELIGIBILITY

Following an initial comprehensive evaluation, the relevant *Multidisciplinary Evaluation Team (MET)* form(s) is/are completed. If the evaluation is an initial evaluation, or there is consideration of changing a special education area of disability, it would be considered a Multidisciplinary Evaluation Team (MET) recommendation. The IEP Team reviews evaluation data and other information presented to them and then determines eligibility (see *Timeline for Special Education Evaluations Flowchart*, Appendix G ). An ICISD *Speech and Language Impairment Eligibility MET form* **must** be completed whether or not the student qualifies for speech and/or language services (see Appendix H for Speech MET).

### Diagnostic Assurance Statements

The MET form specifies three diagnostic assurance statements which are based on IDEA regulations and Michigan rules. The needed information to complete these statements is derived from the documentation provided from both early intervening services **and** the comprehensive evaluation. This includes test (standardized and non-standardized) results, observations, relevant medical information, and information from parents.

- The educational performance of this student is **adversely affected** by a communication disorder;
- The suspected disability **is not due** to limited English proficiency nor lack of instruction in math or the essential components of reading, **and**
- This student **requires specially designed instruction** available only through special education.

These three statements must be true for the student to have a disability under special education (IDEA) law. The student may have a disability, but if it does not adversely affect his/her educational performance, is due to limited English proficiency or related to lack of instruction in math or reading, he/she is not eligible for special education. If these statements are true, but his/her needs can be met in the general education setting without special education programs/services, then he/she is not eligible.

### Speech-Language Impaired as a Primary Disability

When the early intervention and evaluation procedures have been completed and indicate a disability, and the assurance statements have been determined to be true, the student is eligible for special education. If the only area of concern is speech and language and that is the only area in which all the eligibility criteria has been met, the student would have a "primary disability" in this area.

### Speech-Language Impaired as a Secondary Disability

In cases when a student is referred and evaluated in more areas than speech and language, **careful** consideration needs to be given to any and all areas in which the student may have a disability. When the student has been determined to qualify for spe-

cial education with an impairment other than SLI, the label other than SLI should be used for the primary disability.

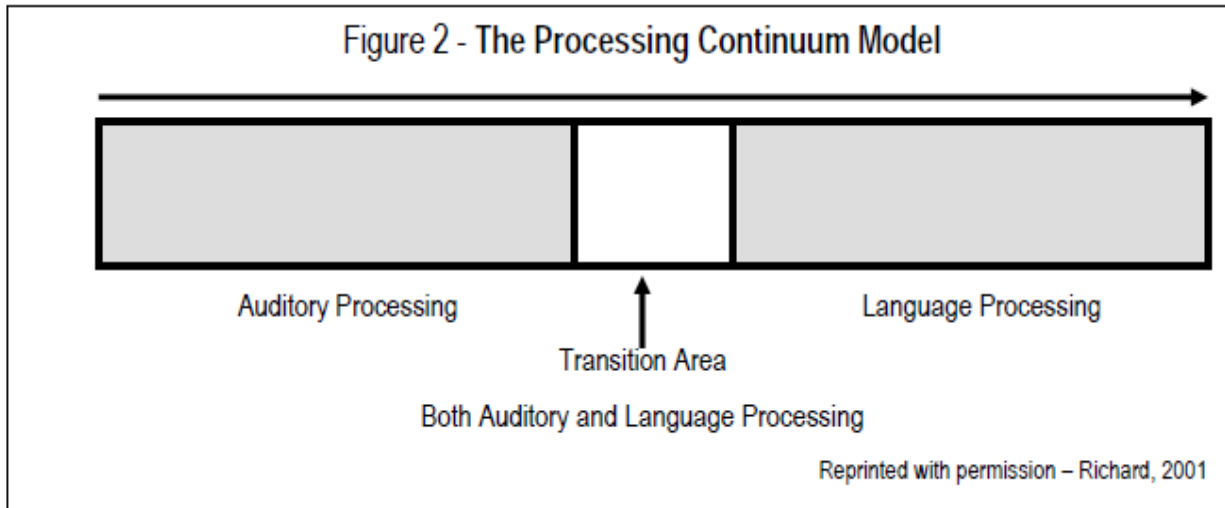
A secondary SLI label is **strongly** discouraged and should **rarely** occur if at all—and **only** as directed by the district special education coordinator. Remember, **a secondary SLI label is not required for a student to receive service**. Services can be provided as a related service. However, in such cases, a diagnostic report is still required per MI Rule 340.1745.

## **Auditory Processing Disorder**

An auditory processing disorder (APD) is sometimes also referred to as Central Auditory Processing Disorder (CAPD). **APD is not defined in IDEA regulations or the Michigan rules because it is NOT a special education eligibility category.** Richard (2001, p. 8) states, “While most professionals can cite behavioral and academic examples of processing, few can clearly explain what processing entails.” ASHA (1995) says it is a difficulty in the perceptual processing of auditory information in the central nervous system. Based on this information, ICISD’s position is that a diagnosis of APD does not guarantee a student’s eligibility for special education programs and/or services.

APD is discussed in the *MSHA Guidelines* (APD-1). Although this section is brief, it provides a good foundation from which to build an understanding of this complex concept. *The Source for Processing Disorders* (Richard, 2001) is referenced and provides more comprehensive information. MSHA uses a working definition of APD as *what is done with what is heard*. Language development can be affected when the auditory system is unable to appropriately respond to auditory input.

An APD is different from a language processing disorder (LPD). APDs involve the ability to perceive and assign meaning to sounds. LPDs involve processing verbal information that requires a verbal or nonverbal response. ICISD’s position is that APD is generally associated with the medical field and is evaluated and diagnosed by an audiologist—and **should NOT be diagnosed by any employee of the ISD or district**. LPD is an educational term, but is not a special education eligibility in and of itself. Richard (2001) explains that auditory processing and language processing lie on a continuum. Characteristics of APD and LPD (MSHA, 2006; Richard, 2001) are presented in the following tables.



Richard (2001) states “...processing is moving back and forth between auditory features of the signal and language features of meaning. In other words, processing occurs on a continuum beginning at a level of pure auditory processing, transitions to a mix of both auditory and language processing, and ultimately end in pure language Processing.”

<b>Table 2 – Characteristics of Auditory Processing Disorder and Language Processing Disorder</b>	
<u><b>Auditory Processing Disorder</b></u>	<u><b>Language Processing Disorder</b></u>
<ul style="list-style-type: none"> <li>• History of otitis media</li> <li>• Normal pure-tone hearing</li> <li>• Poor short- and long-term memory</li> <li>• Difficulty following oral directions, especially in noise</li> <li>• Frequent requests for speaker to repeat themselves</li> <li>• Poor attention span/daydreams</li> <li>• Possible mild speech and language issues</li> <li>• Possible problems with academics</li> <li>• Possible behavioral problems</li> <li>• Fatigues easily during auditory tasks</li> <li>• Age-commensurate IQ</li> <li>• Poor prosody</li> <li>• Poor rhyming and/or musical skills</li> <li>• Reading and/or spelling difficulties</li> <li>• Difficulty localizing</li> </ul>	<ul style="list-style-type: none"> <li>• Age-commensurate IQ and vocabulary with academic deficits</li> <li>• Difficulty with word retrieval</li> <li>• Use of neutral, generic, or less-specific labels</li> <li>• Problems with pragmatics</li> <li>• Misuse of words with a similar phonetic structure</li> <li>• Incomplete sentences or thoughts</li> <li>• Reauditorizes the stimulus (verbal repetition)</li> <li>• Delayed response time (use of fillers, etc.)</li> <li>• Frequently responds “I don’t know or “I forgot”</li> </ul>
Reprinted with permission – Richard, 2001	

## Part 1: Critical Issues – Eligibility

If a school is informed that a student has been diagnosed with an APD, the early intervention team for that building should gather information to determine if the student is having difficulties in school. Questions should include asking if the teacher and/or family have to make any special modifications for the child to succeed. For example, if the child has to spend six hours per week studying so they can pass their spelling test and everyone else only needs one, that should be a red flag. Does the teacher need to have an aide work with the child in order for them to get their work done?

If he/she isn't having academic difficulty, then nothing further needs to be done. If he/she is, then interventions as discussed in the early intervention section need to be implemented. It is the ICISD's position that intervention(s) should be language-based and relevant to the curriculum. *Strategies to Improve Auditory Performance*, from the *MSHA Guidelines* can be helpful in either situation (see *Optional Tools* section of these guidelines).

If the student is having academic difficulties that cannot be resolved with these interventions and/or other research-based interventions, then the student may have a disability. This is uncommon when there are no co-morbid problems such as Attention Deficit-Hyperactivity disorder (ADHA), anxiety issues, LD, SLI, but when it exists and significantly impacts the educational progress of a student, it can be evident as a learning disability in listening comprehension. Both the speech-language pathologist and school psychologist must be involved in an evaluation of this type. For additional information for addressing listening comprehension, see the *MSHA Guidelines*.

## PART 1: PROGRAMS & SERVICES

### Introduction

The IEP Team determines eligibility. Determination is based on the evaluation(s) and other relevant information presented by the team. Following a determination of eligibility, the team determines and writes the student's present level of academic achievement and functional performance (PLAAFP) for the IEP report.

### Present Level of Academic Achievement and Functional Performance

The present level of academic achievement and functional performance (PLAAFP) is the foundation on which the rest of the IEP is developed. The narrative summary of a PLAAFP must include four elements:

1. Baseline data for each area of need—Baseline data should include both strengths and concerns, but must include data related to the area(s) of the disability. Data may be derived from tests, classroom performance (such as work samples, teacher-made tests, etc.), documented observation (written, systemic, ongoing), and/or state or district-wide assessments. Other data sources include provider logs, checklists, attendance records, and other sources.
2. A detailed starting point for instruction—A detailed starting point for instruction must describe the target skills with enough detail to give a starting point for instruction.
3. Identification of areas of need—Areas in which the student requires specially designed instruction needs to be identified. Each area must be addressed in at least one of the following:
  - Annual goals,
  - Supplementary aids/services/supports, or
  - Secondary transition plan/services.
4. An impact statement—An impact statement is a description of how the disability affects the student's progress in the general education curriculum and involvement in age-appropriate activities.

### Placement

First and foremost IDEA regulations require that students with disabilities must be educated in the least restrictive environment (LRE). This requires that they be educated with children who are not disabled to the maximum extent possible. The term placement refers to points along the continuum of programs and services, not to the physical location. Special education placement is determined by the IEP Team based on needs identified in the PLAAFP.

A continuum of alternative placements must be available to meet the needs of students with disabilities. This includes programs and related services. Some smaller districts

may not have enough students with disabilities in lower incidence categories or with specific needs to have every alternative available at a student's local school, or even within the district. In these cases, districts make available placements through cooperative arrangements with other districts in Ionia County ISD. The placement decision is made on an individual student's needs, not on what is available in a specific location.

Students eligible for special education who have a need for speech-language services should receive services that are:

- Curriculum-based,
- Outcome-oriented,
- Educationally relevant,
- Designed to improve the student's ability to access and make progress in the general curriculum and, for preschoolers, in age-appropriate activities,
- Centered around student need, and
- Research-based.

Students with a SLI label will generally be placed on the caseload and receive services from the speech-language pathologist. Services may be provided in a variety of ways but must be specially designed to fulfill the requirements for the student to progress in the general curriculum. These students usually remain in their general education classroom. Possible models of services may include:

- Consultation with the general education teacher,
- SLI services within the general classroom setting (push-in services),
- Small groups in a pull-out setting, or
- Individual sessions in a pull-out setting.

Some students with cognitive impairment, physical impairment, severe multiple impairment, or autism spectrum disorder may require categorical special education programs and/or alternate curriculums. **Speech-language needs for these students can often be met by the special education teacher with or without a speech-language pathologist consultation.** Depending on the curriculum, there may be some situations when small group or individual services may be necessary for varying periods of time.

There may be rare occasions when a student has such a severe speech-language impairment that he/she may require a special education placement with a teacher consultant or a special education program, yet meets only the SLI criteria.

### **Speech-Language Services as a Supportive Related Service**

Neither IDEA regulations nor the Michigan rules require a second disability label (SLI) for a student to receive services from a speech-language pathologist. Ehrens (May, 2007) and Staskowski (2007) recommend providing speech-language pathologist as an added service when appropriate. With a required written diagnostic report provided by the speech-language pathologist, speech and language services may be added to

an IEP for any student who qualifies for special education under another category. Services should provide the necessary support for: the student's area(s) of need identified in the present level of academic achievement and functional performance; goals and objectives; and progress in the general curriculum. A placement of speech-language pathologist services as a supportive related service differs in procedure for a student with SLI as an identified area of primary or secondary disability. For a SLI eligibility label, both a REED and a MET form for speech and language impairment are required. In addition, a REED is required when adding a student to, or exiting a student from SLI services as well as for three-year reevaluation IEPs.

A diagnostic report by the speech-language pathologist is also required in the cases described above. There are no regulatory standards for the content of a diagnostic report. A written document should reasonably justify the speech-language pathologist services provided, and give a baseline for future consideration of continuation or termination of such services. When SLI services are provided only as a related service, the MET form is not required. However, a diagnostic report is still required.

## **Dismissal of Speech and Language Services**

**Dismissal of speech language service**—When SLI is not a category of eligibility, dismissal from speech-language services can be made only when the student is determined by an IEP Team to no longer require direct speech-language services. A REED and a written diagnostic report by the speech-language pathologist is always required. Under these circumstances the discontinuation of related service should be documented in an IEP. Dismissal from service is distinctly different from terminating a SLI eligibility.

### **Consideration for Dismissal from Speech—**

- Completion of all goals on the IEP, no longer a speech or language impairment;
- Secondary label of SLI is no longer appropriate with the primary eligibility taking precedence for existing communication differences;
- Lack of benefit from services documented by speech-language pathologist;
- Dual support is being provided within other services of special education;
- ELL, cognitive impairment, autism spectrum disorder factors indicate language/communication meet expectations;
- Speech and language abilities no longer interfere with academic and/or vocational functioning.
- (For additional reasons for dismissal, see MSHA, pp. SLI-9 & 10)

**Termination of a SLI eligibility**—If the student has a SLI label, determination of ineligibility as SLI by an IEP Team requires a REED and a subsequent evaluation (as needed). Dismissal does require a written diagnostic report documenting why the SLI label is no longer appropriate. An IEP **must** be held whenever the student has a SLI label. When SLI as a category of disability is terminated, speech-language pathologist

services are not necessarily terminated. A student may still receive speech-language pathologist services as a supportive related service for another (replacement) category of disability as appropriate and indicated by the diagnostic report.

**Consultation for IEP Goals and Objectives**—An IEP Team may determine that a student with an IEP does not need direct speech-language pathologist services, but speech-language pathologist consultation support for remaining special education providers is appropriate. Consultation is documented in the IEP as a **related service**. If listed as "consultation" in the section "Supplementary/Aids/Service" on the IEP, then the therapist does NOT need goals/objectives. The speech-language pathologist consultation should be focused on helping special education providers address goals and objectives on the IEP. To verify service delivery, the speech-language pathologist should log dates and topics of consultation contacts.

**Monitoring for Observation/Screening not Directly Linked to IEP Goals and Objectives**—After terminating direct speech-language pathologist service for a student, it may be appropriate for the speech-language pathologist to continue involvement in general screening, observation, or individual screening as described in the Evaluation section of this document. Monitoring activities may also include crisis intervention, assistive technology or other prosthetic equipment issues, or classroom material preparation. If the student will otherwise continue to have an IEP under another eligibility after termination of direct speech-language pathologist services, monitoring activities should be documented in the "Supplementary/Aids/Service" section of the IEP as a supplementary aid or accommodation (specifying frequency and location for when monitoring occurs).

### **Obligations to Nonpublic and Home Schools**

In Michigan law the term "nonpublic school" also applies to a **registered** home school. In Michigan's *Auxiliary Services Act*, public districts must provide auxiliary services to nonpublic elementary and secondary schools within its boundaries. All special education related services are included in the Act. A public school must provide the same auxiliary services (and thus all special education related services including speech-language pathologist services) on an equal basis to pupils in the elementary and secondary grades at the nonpublic school. As for any IEP, these special education related services must address needs related to student achievement and functional performance. But for students in nonpublic schools, public school personnel may not directly provide instruction in the areas of core academic curriculum, as defined by Michigan Curriculum Framework, the Michigan Merit Curriculum, and the associated Michigan Grade Level Content Standards. The core academic content area remains the responsibility of the nonpublic school.

Evaluation services for special education are also an auxiliary service. Public school speech-language pathologists may therefore be involved in evaluations of students attending local nonpublic schools. If the outcome of an evaluation results in special education eligibility, some likely IEP or Non-Public Services Plan considerations are:

1. **A proposed IEP/Non-Public Services Plan for only related services** – The parent may decide to retain the student’s enrollment at the nonpublic school, and the related services may be provided by the public district at the nonpublic school or other IEP Team determined site.
2. **A proposed IEP/Non-Public Services Plan determines the need for a special education classroom program** – If the student requires specialized instruction beyond related services. The student’s **resident** public district is obligated to offer special education classroom programs to the student. This requires coordination between districts if the resident district is not where the nonpublic school is located. In such cases, options to meet student needs include the following:
  - a. The parent may decide to enroll the student in their resident public district to access the special education classroom program as well as related services.
  - b. The parent may decide to retain the student in the nonpublic school with enhanced general education support, and with supportive special education related services provided by the public district serving the nonpublic school.
  - c. If a potential need for a special education classroom program is anticipated during the evaluation, public school staff should be especially prompt in involving the parent and resident district so that all parties are aware of the issues about needs and solutions that will be discussed at the IEP Team meeting.
3. **Dual Enrollment** – Whether involved in special education or not, any student may simultaneously enroll in both the resident public district and a nonpublic school. In dual enrollments, the public school is still restricted from providing instruction in core curriculum as described above.
4. **The Auxiliary Act does not apply to preschool children** – Since the *Auxiliary Services Act* does not include preschool, questions about special education services should be directed to the student’s resident district. Consultation, evaluation, and special education programs/services are all the responsibility of the resident district. An IEP **must** be completed for eligible preschool-aged children. Once in kindergarten, then a Non-Public Services Plan is to be substituted for the IEP for any student continuing to remain enrolled with the non-public school.

The topic of public services to nonpublic schools is more complicated than presented in this brief summary. For example, issues often involve distinctions among programs/services and accommodations, and core versus non-core curriculum. For further information, contact your district administration or refer to policies in *Information on Non-*

Part 1: Programs & Services

*public and Home Schools* published by the Michigan Department of Education.

## CASELOAD, WORKLOAD, & SCHEDULING

### Caseload and Workload

The term **caseload** refers to the students who are receiving direct services and have an Individualized Educational Program (IEP). The term **workload** includes not only the speech-language pathologist's caseload but also encompasses the many additional activities which speech-language pathologists perform in the school setting.

Workload includes:

- Direct services to students including instruction, interventions, and evaluations;
- Indirect services to support the implementation of the students' IEPs;
- Indirect activities that support students in the least restrictive environment and in the general education curriculum;
- Activities that support compliance with federal, state, and local mandates and activities that result from membership in a community of educators.

SLPs with higher caseloads may consider use of alternative delivery models (i.e., consultation, team teaching, push-in, speedy-speech, alternative scheduling) to help manage their workload. In addition research indicates that the use of trial intervention has been found to reduce caseload.

### Scheduling

Within each district the populations of students served vary from students with severe multiple impairments, to students with autism spectrum disorder, to students with mild articulation impairments. No one model will work for all populations and all age groups. Individualized Education Programs (IEPs) need to remain individualized, and must not be created to fit existing models of service delivery. IEPs should reflect individual student needs in every manner, including the model of service delivery. Several scheduling options that depart from traditional service must be considered to help better manage speech/ language workloads.

**Flexible Scheduling**—According to the *MSHA Guidelines* this model combines service delivery options and provides opportunities for individual, small group, classroom and indirect services while allowing the speech-language pathologist to schedule other job related responsibilities. Some schedules rotate students so they are served six weeks on then six weeks off (or another predetermined length of time), to allow more students to be served. Results reported anecdotally are said to be as good as, or better than, the more traditional articulation therapy. Time is blocked in a week to meet the specific needs of students.

**3:1 Model**—(Three weeks of direct service: 1 week of indirect service) In this model three weeks of a four week cycle are dedicated to providing direct services to students (individual therapy, small group therapy, push in lessons and evaluations) while the other week is reserved for indirect services such as consultation, collaboration, devel-

oping materials, and completion of paperwork including Medicaid billings. A variation of this model is a weekly version where four days include direct services and the fifth day is reserved for indirect services.

**Creative Scheduling**—This schedule involves varying times in a schedule to meet the needs of the students, but the service provided to that group may differ by day. Some days may include direct service provision to the students in the therapy room. Some days may include push-in services in the classroom and some days may include individual sessions with the students.

**Speedy Speech/Five Minute Articulation**—Many speech-language pathologists around the state offer services to students utilizing sessions that are shorter sessions but with higher intensity and/or frequency. The speech-language pathologist drills the student with mild to moderate articulation impairments in short, individual (5-minute), and frequent (daily, three times a week) sessions. Sessions may occur near the classroom to decrease transition time.

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## ARTICULATION & PHONOLOGY

### Introduction

Errors in sound production are generally classified as motorically-based or cognitively/linguistically based (Bernthal and Bankson, 1988). In these guidelines, all speech errors are combined under the category of articulation and phonology. Motorically-based errors are generally called articulation impairments and may be characterized by the omission, distortion, substitution, addition and/or incorrect sequencing of speech sounds. Cognitively/linguistically-based errors are referred to as impairments of phonological processes.

### Prevention

Speech-language pathologists have a role in educating school personnel and parents about normal articulation and phonological development. Teachers and parents may be interested in promoting articulation development by providing correct models, listening activities, and by discussing articulation placements during instruction. For example, a kindergarten or first grade teacher may discuss tongue placement when introducing sounds for each letter or during phonological awareness activities. Increasingly, speech-language pathologists are providing phonemic awareness instruction to children, both with and without identified communication impairments, in the classroom as part of prevention initiatives. Mass articulation screenings have not been in practice in Michigan for some time. There is some discussion in the literature of this practice being renewed within a response-to-intervention (RtI) framework applied to articulation (Moore-Brown & Montgomery, 2004). Most typically, though, children's articulation and phonological disorders are identified through teacher and parent referral.

### Early Intervening

When a teacher or parent has concerns about a student's articulation, s/he consults the speech-language pathologist. The speech-language pathologist observes and screens (with proper permissions and procedures) the student's speech, talks to the child's parents and teachers, and discusses how the student's articulation difficulties may be affecting educational performance. Speech-language pathologist may initiate the trial intervention procedures (refer to the *Screening to Evaluation Flowchart*, see Appendix D). If the staff believes, with consultation from the speech-language pathologist, the errors in articulation may be resolved without speech-language pathologist intervention, then the speech-language pathologist suggests strategies and follow-up for the student, teacher, and parents to use.

If the student begins to progress adequately, interventions/suggestions will continue to be used as needed by the teacher and/or parents. When there is adequate student progress in response to the interventions, no referral is necessary. If it is determined that the student is not making adequate progress based on data collected, the special education evaluation process should begin. The parent will be contacted to complete a REED.

**Articulation and Phonology Testing**—Formal assessment may include both articulation and phonology. Norm-referenced tests which are both valid and reliable should be administered. A speech-language pathologist should use caution in the interpretation of standardized scores to determine the need for services. Although some assessments will reveal standardized scores below the average range for single sound errors, services may not be necessary if there is not adverse educational affect. It is important to consider **all** aspects of the *Articulation Eligibility Guide/Team Summary* (See *Optional Tools* section of these guidelines) to determine the need for services.

**Summary of Adverse Educational Affect and Eligibility**—Based on the information gathered, the team decides whether the student is experiencing an adverse educational affect as a result of articulation or phonological errors. If it is determined that articulation or phonological errors and concerns negatively impact the student's ability to be successful in the general education environment (nonacademic and academic communication and classroom participation) **and** cultural/linguistic or environmental/economic differences are absent, then special education eligibility should be considered. If there is not an adverse educational affect, the student is not eligible for special education services even if the child demonstrates some articulation errors. **Both (1) the presence of errors and (2) an adverse affect on education requiring specialized instruction MUST be present to be considered eligible.** An ICISD *Speech & Language Impairment Eligibility MET* form **MUST** be completed whether or not the student qualifies for speech and/or language services (see Appendix H).

**Dismissal Criteria**—Please refer to pages SLI9-SLI10 of the MSHA Guidelines (see Appendix I). Speech-language pathologists should keep in mind that there is research suggesting that **students who are dismissed at 75-85% accuracy in conversational speech often go on to fully correct [errors], suggesting that this is an appropriate time for dismissal** (Diedrich, 1980).

## Articulation Norms

There has been much discussion and varying opinions regarding which of many articulation sound charts should be used to determine when a student should be expected to have acquired specific sounds. The ICISD recommends using the *Iowa-Nebraska Articulation Norms* (see *Optional Tools* section of these guidelines). This recommendation is based on the replication of the results over time and the frequency with which states have adopted these norms as their standard for statewide guidelines for speech and language. [see Bowen, C. (2006). *Phonological Development* retrieved from <http://www.speech-language-therapy.com/Table3.htm> on 6-29-10.] (See also *Phonological Process Definitions* located in the *Optional Tools* section of these guidelines).

The most recent study of these norms was in 1990 (Smit, Hand, Freilinger, Bernthal, & Bird). This study was a replication of studies in 1957, 1967, 1975, 1976, 1986 and 1988. The findings of Smit, et al (1990) demonstrate that the ages of acquisition of tested consonant single sounds have generally remained constant or moved to earlier

## Part 2: Articulation and Phonology

ages. Ages of acquisition for a few phoneme singles and for most clusters have either remained constant or have moved to slightly later ages.

No single piece of data should be used to identify a student with a disability.

## FLUENCY

**Definition of Stuttering**—*Disfluency (stuttering) is an abnormally high frequency or duration of stoppages in the forward flow of speech that occurs in the form of repetitions of sounds or syllable prolongation of sounds, blocks of airflow or voicing. Often accompanied by awareness, embarrassment, signs of physical tension, or increased rate of speech (MSHA, 2006, F-2).*

*Cluttering is a disorder of speech and language processing resulting in rapid, dysrhythmic, sporadic, unorganized, and frequently unintelligible speech. Accelerated speech is not always present, but an impairment in formulating language almost always is (MSHA, 2006, F-2).*

**Early Intervention**—Teachers and parents who have concerns regarding a student's fluency should consult with a speech-language pathologist to determine if further assessment is necessary. The speech-language pathologist and others will collect information through observations, checklists, and parent and teacher input. Strategies and suggestions related to how a teacher and family respond to the child's disfluency may be made.

If the team feels that with consultation from the speech-language pathologist, the disfluency may be resolved, the speech-language pathologist then suggests strategies for the student, teacher and parent to use. The speech-language pathologist then follows up periodically. The speech-language pathologist may also elect to use trial intervention to document this process. If the difficulty persists, then a complete speech and language assessment may be necessary.

If there appears to be disfluency that adversely affects the child's educational performance which needs direct intervention from the speech-language pathologist, the evaluation process will begin and parent consent for evaluation will be needed. An example of when to immediately use the formal assessment process might include a case where there is a family history of stuttering behavior, and the student shows multiple secondary characteristics and disfluencies, along with self-awareness of the disfluent behavior. (MSHA, 2006)

**Input**—Input from teachers, the student, and parents are all important components of the fluency assessment. Examples of checklists from the MSHA Guidelines (2006) can be found in the *Optional Tools* section of these guidelines. Reviewing family history, student self-esteem, motivation/attitude, and self-assessment of communication as it relates to their fluency are all important information to be considered.

**Risk Factors**—There are several risk factors that increase the likelihood that a student will continue to stutter. See table following.

Table 4 - **Fluency Risk Factors** (Ainsworth & Fraser, 2006; Yairi & Ambrose, 2005)

<b>Risk Factors</b>	<b>Where Obtained</b>	<b>Present or Absent</b>
<b>Male</b> (stuttering affects males 3 – 4 times more than females.) Females likely to recover without intervention.		
<b>Age of Onset</b> Students who begin stuttering prior to the age of 3 ½ years are more likely to outgrow stuttering. Students who begin stuttering after age 3 ½ years may continue to demonstrate stuttering behaviors.	Parent Input	
<b>Time Since Onset</b> If a student has been stuttering longer than 6 months, they may be less likely to outgrow the behavior on their own. The likelihood [of] a student who has stuttered longer than 12 months increases even more.	Parent Input	
<b>Family History</b> Approximately 60% of people who stutter have a family member who stuttered.	Parent Input	
<b>Presence Other Speech/Language Impairment</b> Students with other speech/language disorders are at higher risk for stuttering (SFA, 2006).	Parent Input	
<b>Pattern of Stuttering</b> If the student is relatively unaware of their disfluencies, the risk for a fluency disorder is reduced compared to a student who is aware of their stuttering. Whole word repetition at the beginning of an utterance is more typical in development than blocks (when phonation is interrupted).	SLP Observation or Parent/ Teacher Re- port	
<b>Sensitivity of Child</b> Students who are emotionally more sensitive may respond to stressful situations with stuttering behaviors.	Parent Input	
<b>Environment</b> Family reaction, fast-paced family schedule, family dynamics such as high expectations, communication style of parents and/or teachers, significant life event (death, divorce, etc.)	Parent Input	

12/2006, Michigan Speech-Language Guidelines APD-6

**Test Administration or Analysis of Frequency and Duration of a Connected Speech Sample**—The primary goal of the initial assessment is to both determine eligibility and to identify an appropriate treatment plan. The speech-language pathologist and team must determine whether a fluency impairment exists, how it adversely affects educational performance (academic, nonacademic, or extracurricular), and how intervention should be designed to help the student to progress in the general education curriculum. (See the *Stuttering Severity Instrument* [MSHA, 2006, F-14] found in the *Optional Tools* section of these guidelines.)

**Classroom Observations of Adverse Effect**—Observe the student during a time of

## Part 2: Fluency

day when the teacher indicates student's disfluencies interfere with participation. Collect more information regarding whether the student's fluency is adequate for successful participants in that curricular task or whether the student lacks the fluency skills and strategies needed.

**Cluttering**—Analyze disfluencies for differential diagnosis of stuttering versus cluttering. Please refer to these checklists in MSHA, 2006, F-17 and 18 found in the *Optional Tools* section of these guidelines.

**Other Assessment Information**—The speech-language pathologist should complete a broad-based screening of language, articulation, oral-motor, and voice to explore the possibility of additional impairments.

**Summary of Eligibility in Fluency**—If there is documented evidence of stuttering and/or cluttering **and** an adverse impact on educational performance, and absence of cultural/linguistic or environmental/economic differences, then the student should be considered eligible as speech and language impaired in the area of fluency. **Both a disability and an adverse educational effect MUST be present to be considered eligible. Evidence of only one of these criteria cannot justify eligibility as a student with a disability.** An ICISD *Speech & Language Impairment Eligibility MET* form **MUST** be completed whether or not the student qualifies for speech and/or language services (see Appendix H).

## VOICE

**Definition**—A voice impairment is defined as the abnormal production and or absence of vocal quality, pitch, loudness, resonance, and or duration which is appropriate for an individual’s age and or sex (ASHA, 1993, p. 40). When this disorder adversely affects educational performance, then a voice impairment may be present as described in the Michigan rule.

**Early Intervention** – Teachers and parents with concerns regarding a student’s vocal quality should consult with a speech-language pathologist to determine if further assessment is necessary. The speech-language pathologist and others will collect information through observations, checklists, and parent and teacher input (see *Voice Eligibility Guide/Team Summary* located in the *Optional Tools* section of these guidelines). When students present with laryngitis or hyponasality, a brief conversation about the duration, symptoms and possible presence of a cold or allergies can alleviate concern. The speech-language pathologist listens to the student’s voice, interviews the parents, and together with the classroom teacher determines how the student’s voice adversely affects educational performance.

If the team feels that with consultation from the speech-language pathologist, the vocal quality may be resolved, the speech-language pathologist then suggests strategies for the student, teacher and parent to use. The speech-language pathologist then follows up periodically. The speech-language pathologist may also elect to use trial intervention to document this process.

If there appears to be vocal quality that **adversely affects the child’s educational performance** which needs direct intervention from the speech-language pathologist, then a referral or *REED* process will begin and parent consent for evaluation will be obtained. A request for a medical evaluation, such as a visit to an otolaryngologist (ENT), may occur during the early intervening or evaluation process. (See Appendix J for a list of ENTs near Ionia County.)

**Input**—Ideally, the parent provides a written medical report from a laryngeal examination for the evaluation for voice structure and function. Input and interviews from teachers, the student, and parents are all important components of the vocal quality assessment. Interviews with non-classroom school personnel will help determine whether there is vocal abuse/misuse in a variety of settings. Parent interviews may reveal environmental factors such as second-hand smoke, food allergies, and medical conditions, such as sinusitis, enlarged adenoid/tonsils, and bulimia. Examples of checklists are found in the *MSHA Guidelines (2006)* and in the *Optional Tools* section of these guidelines.

**Consideration of Cultural/Linguistic Differences (CLD)**—It is important to investigate cultural and linguistic variables that may affect voice production. Cultural variations can influence variations in volume, pitch, and quality.

**Consideration of Temporary Physical Factors**—Voice difficulties as a result of temporary physical factors should not be considered as a voice impairment/disability. These might include factors such as allergies, sinusitis, gastroesophageal reflux, colds, abnormal tonsils or adenoids.

**Vocal Quality**—Use observations, checklists, or interviews to assess the student’s vocal characteristics looking for difficulties such as breathiness, stridency, or hoarseness. Breath supply should be evaluated for the amount and efficiency of air to sustain speech. Phonatory efficiency should be evaluated to assess the student’s ability to sustain quality phonation. Muscle tension during speech production should also be evaluated looking for signs of hypertension, hypotension, and anxiety when speaking.

**Pitch**—Use observations, checklists, or interviews to assess the student’s use of pitch looking for difficulties such as extraordinarily high or low pitch, pitch breaks, or monotone.

**Loudness**—Use observations, checklists, or interviews to assess the student’s use of loudness, looking for difficulties such as excessive loudness, or softness.

**Resonance** —Resonance disorders are usually the result of a variety of structural abnormalities such as cleft palate, and velopharyngeal insufficiency (hypernasality) or nasal polyps and enlarged adenoids (hyponasality). Use of observations, checklists or interviews to assess the student’s resonance, looking for difficulties such as hyponasality, hypernasality, nasal emissions, and/or assimilation nasality on vowels.

**Additional Areas of Assessment for Planning Intervention**—Use observations, checklists, or interviews to assess: breath rate, phonatory efficiency, muscle tension, intelligibility, and speech avoidance.

**Summary of Eligibility in Voice** – If there is evidence of a voice disorder, an adverse impact on educational performance, and the absence of cultural/linguistic or environmental/economic differences, then the student should be considered eligible as speech and language impaired in the area of Voice. **Both a disability and an adverse educational effect MUST be present to be considered eligible. Evidence of only one of these criteria cannot justify eligibility as a student with a disability.** An ICISD *Speech & Language Impairment Eligibility MET* form **MUST** be completed whether or not the student qualifies for speech and/or language services (see Appendix H).

## LANGUAGE

### Overview

According to the Michigan Speech-Language-Hearing Association, “The prevention, assessment and intervention for language impairments are the most common activities of the school-based speech-language pathologist” (MSHA, 2006). Participation, access, and progress in the general education curriculum are dependent upon a student’s skills in oral and written language. (**NOTE:** Federal Requirements [§ 300.304 (2)] regarding evaluation procedures—*In conducting the evaluation, the public agency must not use any single measure or assessment as the sole criterion for determining whether a child is a child with a disability and for determining an appropriate educational program for the child.*)

**Definition of a Language Disorder**—ASHA (1993, p. 40) provides the following definition of a language disorder and its components:

*A language disorder is impaired comprehension and/or use of spoken, written and/or other symbol systems. The disorder may involve (1) the form of language (phonology, morphology, syntax), (2) the content of language (semantics), and/or (3) the function of language in communication (pragmatics) in any combination.*

*1. Form of Language*

- a) Phonology is the sound system of language and the rules that govern sound combinations.*
- b) Morphology is the system that governs the structure of words and the construction of word forms.*
- c) Syntax is the system governing the order and combination of words to form sentences and the relationships among the elements within a sentence.*

*2. Content of Language*

- a) Semantics is the system that governs the meanings of words and sentences.*

*3. Function of Language*

- a) Pragmatics is the system that combines the above language components in functional and socially appropriate communication.*

**General Education Interventions**—It is recommended that when students are suspected of having language concerns, the same process be used (ICT and early intervention strategies) as when districts consider the presence of other potential learning difficulties.

If general education interventions have been implemented and progress does not occur, it may be decided to formally assess a student’s language skills.

## Part 2: Language

When the decision is made to pursue a formal assessment of a student's language skills, the primary goal of an initial assessment is to answer the following questions:

- Does a language impairment exist?
- Does the language impairment have an "adverse educational impact" on school performance in the academic, nonacademic, and/or extracurricular domains?
- Does the student require specialized instruction?

**Determining Eligibility for Language Impairment**—The following information and documentation is required to determine eligibility for special education as a student with a speech-language impairment:

- Ability/achievement/developmental level,
- Relevant behavior observations,
- Speech/language level,
- Spontaneous language sample,
- Educationally relevant medical information, and
- Information from parents.

Sample forms are available in the *MSHA Guidelines* (2006), L-13,15-17, et seq. and can be found in the *Optional Tools* section of these guidelines.

**Ability/Achievement/Developmental Level**—Assessment information regarding a student's ability level, achievement level, or developmental level may be available from psycho-educational, school social work, physical therapy and/or occupational therapy evaluation reports. Information from progress monitoring procedures (such as DIBELS, MLPP), group standardized achievement tests (such as the Iowa Test of Basic Skills, Terra Nova, Gates Reading Test, etc.), writing rubrics, or content specific measures (e.g., integrated theme tests in reading, district-wide assessments of reading and mathematics) should also be gathered and considered as part of the assessment process.

A review of accommodations, modifications, and interventions that have been provided to the student through ICT and the intervention model should be completed. These strategies and the student's response to them need to be documented.

**Relevant Behavior Observations**—Information regarding behavior in the school environment may be found in the student's cumulative file, prior evaluations, reports by private providers and public and/or private agencies, as well as the teacher and the parent input forms.

**Curriculum-Based Assessments**—Curriculum-based language assessments should also be reviewed. These assessments measure whether the student's "language behavior" is adequate to successfully participate in the curricular tasks at his/her grade level or whether the student has the needed skills or strategies to accomplish grade level tasks (See *MSHA Guidelines*, pp L-19 through L-24 & L-35 through L-40).

**Speech-Language Level**—Multiple forms of assessment are required by IDEA 2004. It is the ICISD's position that language assessment/data should include parent input, teacher input, a file review, curriculum-based language assessment, language samples, standardized test results, and outside speech-language assessments if provided by the parents. The standardized test profile is only one factor to be considered in the assessment profile when determining eligibility. As a **general** guideline, the ICISD recommends 1.5 deviations below the mean standard score of 78 ( $x=100$ ;  $SD=15$ ). Standardized test(s) chosen for the assessment should be reliable and valid, and have adequate sensitivity and specificity. (For more information, see page *Part 1: Critical Issues* of these guidelines.) Kent County ISD's specificity and sensitivity data is included in the *Optional Tools* section of these guidelines. (See *Optional Tools* section of these guidelines for tests available via ICISD).

As noted in the section of this document that discusses cognitive referencing, the following points are repeated:

- A cognitive-language discrepancy is not required for making an eligibility decision for SLI;
- A cognitive-language discrepancy should never be the sole determining factor in making any eligibility decision, but it can be a vital piece of understanding the whole child's abilities and performance;
- Cognitive referencing can be useful in determining reasonable language expectations;
- A cognitive-language discrepancy should be used with extreme caution when determining eligibility for a very young child

**Spontaneous Language Sample**—Best practice in language sampling includes collecting both an oral language sample and samples of the student's written language. Information should be collected for the word, sentence, and discourse levels for both oral and written forms of language.

**Educationally Relevant Medical Information**—Relevant medical information may be obtained from past or current assessments by medical professionals and from the parent. In the school setting, relevant information may include, but is not limited to, information about medical concerns that affect school performance (such as vision, hearing, or attention issues).

**Information from Parents**—Information from parents may be gathered through interviews, checklists, or questionnaires. Information that may be obtained includes birth history, developmental history, health history, medical history, and specific information about the development of speech-language skills.

See sample forms from the *MSHA Guidelines* (2006) located in the *Optional Tools* section of these guidelines.

**Results of Assessment** – The speech-language pathologist and team then consider

all information gathered during the assessment phase including the student's response to general education intervention(s), input from multiple sources, and standardized test results. Next, the team proceeds to summarize information related to the student's suspected disability.

**Summary of Assessment Information**—When all the relevant information has been collected and reviewed, the team considers whether the assessment results support the identification of a language impairment. The speech-language pathologist describes whether this impairment adversely affects the student's participation in the general curriculum.

**Summary of Adverse Educational Impact**—Based on the information gathered and reviewed, the IEP Team decides whether the child is experiencing an adverse educational impact as a result of language impairment. There are two possible outcomes:

- The language impairment negatively impacts the student's ability to be successful in the general education environment (in academic, nonacademic, and/or extracurricular domains), special education eligibility as a student with language impairment would be considered.
- The student has a language impairment which does not have an adverse educational effect, therefore he/she is not eligible for special education services.

It must also be established that the suspected disability is not due to limited English proficiency, lack of instruction in math or the essential components of reading, and that the student requires special education programs/services (Ionia County ISD *Speech and Language Impairment MET form*, Appendix H).

**Summary and Recommendation for Eligibility as Language Impaired**— When it has been determined that a language disability is present which adversely affects educational performance and there is an absence of cultural/linguistic and/or environmental/economic differences, then eligibility for speech and language services must be considered by the IEP Team. An ICISD *Speech and Language Impairment Eligibility MET form* must be completed whether or not the student qualifies for language services.

Once eligibility has been recommended, the IEP Team must describe the present level of academic achievement and functional performance (PLAAFP). This description must describe the needs of the student, identify the evidence aligned to the need, and explain how each need affects the student's ability to access and perform in the general education curriculum.

### **Service Delivery Considerations**

Students who are placed in categorical special education classrooms should receive embedded language instruction through their curriculum, and may not require continued direct speech-language pathologist services. Resources and language enrichment

lessons can be provided to teaching staff. The more that speech-language pathologist services are integrated into the student's daily routine and academic curriculum, the more effective learning will be. Direct service to adolescent-aged students should be limited to skills that can only be delivered through specialized therapy techniques provided by a speech-language pathologist. Students in a resource room program are usually provided teacher instruction related to vocabulary. Understanding terms within the curriculum is more directly tied to their educational program. Instruction in this area may include vocabulary reinforcement through study guides or various modalities of learning, test-taking strategies, learning memorization techniques, visualizing and verbalizing information, resources to draw on, and so on. The speech-language pathologist is available in a consultative role if specific problems arise. If there are pragmatic communication issues that are interfering during this stage of adolescence, then a more direct speech and language intervention may be appropriate. (For more service delivery options, see MSHA, L-30 through L-34 & L46-48).

## **Birth through 5 Years of Age**

### **Birth to Three**

Children in the birth to three age group present some unique issues. These children may qualify for and receive some form of speech-language services under Early On or special education. If a child is eligible for special education, they are also eligible for Early On. The differences between these can sometimes be confusing.

**Early On** – Early On is a term unique to Michigan and refers to Part C of the IDEA. In Michigan, the State Department of Education has been designated as the “lead agency” for the coordination among school and non-school agencies for services to children ages birth through 2. Michigan’s program for children birth through 2 with a 20% developmental delay and/or an established condition is the *Early On* program. *Early On* may merely coordinate services or directly provide services.

**Special Education** – While the IDEA regulations include children ages 3 through 21, special education in Michigan extends this age range downward to birth, and thus includes school-based speech-language pathologist evaluation services for children from birth.

As children served by *Early On* near the age of 3, specific planning activities are provided for transitioning children to appropriate preschool settings for children ages 3 through 5 according to each child’s needs and family situation.

Speech-language pathologists using this section should also refer to the language section for general guidance including the definition of Speech language impairment (Rule 340.1710) in the Michigan rules and Part C of IDEA. Part C, or *Early On* Michigan, specifically focuses on infants, toddlers and their families. Compliance with Part C of IDEA regulations are unique to speech-language pathologists working with children birth to

## Part 2: Language

36 months of age. These regulations impact not only the evaluation and service delivery for these children, but also the referral and consent process.

In Ionia County, the Intermediate school district's early intervention team provides the majority of the assessments for this population. An evaluation for children between birth and three years of age must include: 1) all areas of development, (social-emotional functioning, cognitive skills, motor skills, and speech and language development); 2) relevant medical information including hearing and vision status; 3) a complete history; and 4) an observation of the parent-child interaction. A variety of assessment tools can be used to assess overall development, these include: The Provence Birth to Three, Infant-Toddler Developmental Scale (IDA), Bayley Scales of Infant Development, Battelle and/or the Brigance. These assessments may be provided by other disciplines such as an early intervention teacher, psychologist, social worker or a generalist. If the assessment tool utilized has a separate communication subtest, this information can be reviewed by the speech-language pathologist and utilized with other assessment information to support eligibility or ineligibility for special education services.

If a child is born prematurely, the child's age will be adjusted for comparison and evaluation purposes until the 24th month of age.

An SLP may conduct a complete evaluation after an Early On Consent Form has been secured. From this assessment, a child may be determined eligible for Early On. If the child is suspected to be eligible for special education, the REED must be secured prior to the evaluation being conducted.

**Determining the need for a referral**—Sometimes parents contact the Ionia ISD to inquire about general developmental milestones. These inquiries may result in a developmental screening using the Ages and Stages Questionnaires and/or speech and language developmental information provided to the parent. The speech-language pathologist, or intake staff, may provide this information without beginning a formal evaluation.

However, when a parent, physician or community agency requests an evaluation for a suspected delay, Part C of IDEA requires that an evaluation be completed. This may or may not include a speech and language assessment.

**Conducting the Speech and Language Assessment**—The *Infant Toddler Eligibility Guide/Team Summary* worksheet (see *Optional Tools* section of these guidelines) provides suggestions for how each part of the evaluation should be carried out. The purpose of this form is to provide a framework for organizing eligibility components. The following is a discussion of each component.

**Gather Input**—Formal written consent to evaluate (Early on Consent Form and/or REED) as well as an explanation of the referral process is required before the evalua-

tion begins. A language assessment should begin with a comprehensive interview with parents/caregivers to explore concerns, gather familial history of communication disorders, and obtain the child's medical and developmental history. Particular attention needs to be paid to how the infant/toddler uses language within the context of his or her everyday routines. The routines inventory page of the IFSP can be provided to parents to help gather this information.

Hearing screening is required as part of a birth to 3 evaluations. The AuDx is the recommended method for conducting a hearing screening. The Early On Hearing Development Screening Checklist may also be used. A formal audiologic evaluation and/or consultation by the child's physician may be beneficial to determine the child's specific hearing functioning.

**Observation of Parent-Child Interactive Play**—As with all language evaluations, observe the child's interaction skills in a naturalistic environment during play with the parent or caregiver and/or sibling. Observations of play between comfortable communicative partners can provide a speech-language pathologist with valuable information. This information will be important to compare to results on standardized instruments. For example, did the child use more or less words, make more or fewer communicative attempts, show increased or decreased eye contact, demonstrate increased or decreased direction following structured versus unstructured assessment situations? In addition, this observation can meet the requirement of Part C of IDEA for parent/child interaction to be observed and documented in the evaluation report.

**Communication Information Gathered During Play**—Throughout the play-based evaluation, the speech-language pathologist should provide support and accommodations for the infant/toddler to determine if communication functioning improves. Communication can improve when scaffolding, modeling, picture symbols, gestures or signs are introduced. During this time, the speech-language pathologist should document if the infant/toddler's language improved with such interventions or if he/she continued to have difficulty.

**Prelinguistic Communication and Pragmatics**—During play activities and daily routines, it is vital to collect information regarding the way the child communicates (such as: crying, pointing, intonation) and the functions that it serves (such as: requesting, protesting, greeting, naming, commenting).

When evaluating infants and toddlers who are not yet at the word level, it is important to consider prelinguistic and social-communication aspects of communication. Children begin communicating from birth through pre-intentional communication acts (such as: crying, eye gaze, gestures, sounds). Children then begin using those communication acts in an intentional way before a formal language system develops. An important milestone for this age group is the child's ability to establish joint attention with others by sharing attention and affective states with both eye gaze and facial expression. It is important to provide the child with opportunities to protest, request, and name objects

while considering how the child's communication skills differ across environments and individuals (such as: parents/caregivers, extended family, or others).

**Form (Syntax)**—Mean Length of Utterance (MLU) should be assessed to determine if it is appropriate for the child's age. The speech-language pathologist should so assess how well the infant/toddler understands the commands and sentences are spoken to him/her. Brown's stages should be utilized to assess the presence of various grammatical markers in the child's speech. The table provided by Miller (1981) should be utilized to assist with determining the child's developmental age based upon his MLU. (See *MLU Charts* located in the *Optional Tools* of these guidelines.)

**Intelligibility (Articulation/Phonology)**—If a child does not use words to communicate, an inventory of sounds (consonants and vowels) and syllable types used should be collected. Mastery of age appropriate sounds should be compared to the table in the Articulation section. In addition to assessing the types of sounds a child utilizes to communicate, the child's intelligibility should also be assessed. It is important to determine whether the child is understood by familiar listeners, in context, and if a referent is needed or not. It should be noted if contextual cues were needed to understand the child. If an infant/toddler is described and/or is evidenced as being "frequently unintelligible" by a familiar listener, it would be beneficial to determine the percentage of intelligibility. If intelligibility is a concern, refer to the Articulation section for guidelines.

**Oral Motor Speech Functioning**—During the evaluation process, oral motor structure and function should be assessed. An oral motor evaluation with young children may include observations of motor planning skills, mouth posture during play and rest, drooling, dentition, eating and swallowing skills, and articulator movements.

**Language Sample**—A spontaneous speech sample is required as part of the assessment process. A 25-50 item sample should be obtained in order to complete an appropriate analysis. If the sample is very small it can be embedded with the context of the report. The SLP should report any words that the parent indicates the child says as well.

**Consideration of Cultural/Linguistic Differences**—When an infant/toddler's native language is not English, it is important to consider that the language or cultural differences may be impacting his/her language development. Non-English speaking children at this age often are not exposed to more than one language and the evaluation should take this into account by attempting to determine what is the primary language spoken to the child in the home. Refer to the English Language Learners section for guidelines in this area and Bilingual/Non-English Speaking Families Parent Interview for assistance with determining appropriate language for evaluation.

For young children that are in a bilingual environment and who are demonstrating a language disorder, the common practice has been to recommend that the child only focus on learning one language. The presumption is that dropping a language lessens

the demands and helps the child focus and use his or her resources to master one language. However, the trend is shifting in support of maintaining a bilingual environment.

*In bilingual children, both languages should be supported in the presence of an identified language delay. It was previously thought that it would be better to support only the dominant language of the community at large to avoid confusion for the child i.e. English. This is no longer the view among the experts. The home language is needed to “maintain and promote family connections, cultural links, and the self identity that are necessary for positive social-emotional development and well-being. English is needed to develop and maintain positive interactions with the majority community to maximize educational and vocational opportunities and success.” Also, it is important not to ignore previously acquired knowledge, rather to continue building on knowledge in both languages.*

*By age 3-5 years, at least one language should be equivalent to monolingual norms in normally developing bilingual speakers. At some point there will be a shift in dominance from the child’s home language to the language of the majority community. This is a natural shift and should not be artificially encouraged at a younger age than it would normally occur. The timing of this shift is dependent on many variables.*

*An underlying language impairment will manifest itself in both languages in bilingual children. A bilingual child with language impairment does not have more severe deficits because of the presence of another language as compared to monolingual peers. Bilingual children with language impairment are capable of learning two languages equally as well as their monolingual language impaired peers. Most importantly, there are many ways to support language impaired children with a single minority language, even if the care provider does not have knowledge of that language (Kohnert, K. *Language Disorders in Bilingual Children and Adults*, 2007).*

This would suggest that monolingualism is not an appropriate intervention for bilingual children and efforts should be made to treat children who are demonstrating developmental delays in both languages. With children in particular under the age of three who are eligible for Part C of IDEA (*Early On*), this is very important as parental choice drives the intervention process. If a parent expresses desire that their child’s language intervention be focused on building the child’s native language (ie. Spanish) and there is a delay demonstrated in that language, then that is what the *Early On* and Special Education outcomes should address. (This statement is per consultation and guidance provided by LaPointe & Butler, P.C., 2010)

When internationally adopted infants and toddlers are evaluated for possible speech-language impairment, it is important to consider development specific to this population. Many variables need to be considered including the child’s environment in their native country (placement in orphanage, home care, or other setting), amount of time

spent in this country, age at adoption, and social-emotional factors related to a major life change for this child.

**Formal assessment is required**: Standardized testing is required when evaluating any child's speech and language skills. It is important to be familiar with author's guidelines for interpretation of test scores and to look for variations within the infant/toddler's language profile that may suggest deficits within a language subsystem which should be explored further. A list of commonly used tests standardized for the infant/toddler population is found at the end of this section.

**Summary of Adverse Educational Effect**—A culmination of information gathered from all the above sources should be used to assist in the final determination of whether the infant/toddler's language delay has an adverse effect on educational performance. At this age level, adverse effect can be defined as the impact the delay has on participation in developmental activities, daily routines, and family life. (I.e. Does the child communicate needs, wants etc., follow direction etc. like other children his/her age?)

#### **Eligibility Considerations:**

Determining eligibility for special education or *Early On* for the birth to three population is complicated by the lack of tools available that provide standard scores. As indicated in the language section, the guidance for eligibility is a standard score of 78 which represents 1.5 standard deviations below the mean. Although you will find no evidence in the literature to support the use of age equivalent scores as the sole basis for qualifying a child for special education services, it does need to be factored in for consideration. The states definition of *Early On* supports the use of this concept by indicating that a child must have a 20% delay in development to be eligible for *Early On*. A 30% delay in development would represent a 1.5 standard deviation from the mean. The percentage of *Delay Based on Chronological Age Versus Performance Age* table is provided to assess the degree of delay an infant or toddler is demonstrating. (See Appendix K) A 30% delay in development would suggest the possible need for special education services.

As indicated earlier, no single score should be the determining factor for eligibility but rather all factors must be considered. When determining eligibility for speech language services in the infant/toddler population, consider the following:

1. Results of standardized assessments, criterion-referenced tools and checklists demonstrating language skills below the level expected for the infant/toddler's age.
2. If the child is unable or ineffective in their abilities to express wants and needs or exchange information effectively and appropriately for their age.
3. If the child is unable or ineffective in demonstrating understanding of spoken language.
4. If the child is unable to imitate and/or is not stimuable for any error sounds that are appropriate for his/her age.

The SLP must be skilled in assessing all of the information when making eligibility recommendations. Standardized test scores alone will not provide enough information to make a recommendation for eligibility. Examples of eligibility determinations and their rationale based upon the given criteria are provided in *Optional Tools* section of these guidelines (C. Granzo to send).

If the child is eligible for *Early On* an Individualized Family Service Plan should be developed, if the child is eligible for Special Education then an IEP/IFSP should be developed.

**Considerations for Ineligible Children**—At the conclusion of the evaluation process, children may be determined to not meet the eligibility guidelines for special education or *Early On*. If parents remain concerned, and no delay exists, referrals to community developmental support services can be made as well as providing parents with information on how to support their child’s development and monitor future developmental concerns.

**Providing Services to the Infant-Toddler Population**—There are several basic tenants affecting the speech-language pathologist working with this population:

- Service delivery must be provided in the child’s natural environment, defined as settings that are natural or normal for the child’s age peers who have no disability (IDEA, 1997).
- Provisions must be made for year-round services.
- Parents and caregivers are defined as the primary “client” because they have the most naturally occurring opportunities to interact with the child throughout the day. Parent learning opportunities are provided to educate parents about their child’s developmental delay or disability; provide peer to peer support; provide emotional support and grief counseling; and provide parents access to activities and speakers that will help them support their child’s learning throughout their daily routine in their natural environment.
- After the initial evaluation process, a speech-language pathologist may or may not be the primary worker or service coordinator for the child and family since a “transdisciplinary” model is used in Ionia ISD. In this model, various types of special education service providers work across all areas of early development. The Individual Family Service Plan (IFSP)/Individualized Education Program (IEP) process will determine the goals and outcomes for the child and family. The child’s goals and outcomes will help determine the services to be provided.

(For Commonly Used Standardized Assessments for the Infant/Toddler Population, see the *Optional Tools* section of these guidelines.)

### **Preschool (3-5 year olds)**

In Ionia County, the majority of speech and language services to the preschool population are provided by the local school district. The preschool section of *MSHA Guidelines* (2006, PL) offers some checklists for teachers and parents included in the *Optional Tools* section of these guidelines. This section provides information specific to children in their preschool years, ages 3 through 5. This section should be used in conjunction with the more detailed School Age Language section of this document.

**Pre-Referral/Referral Process**—Typically, a parent/caregiver, preschool teacher, day-care provider, or pediatrician is the first person to become concerned about the preschooler's communicative development. For child-find purposes, the Ionia ISD provides a "no-wrong door" for this population. That is, inquiries and/or referrals will be responded to by either the local school district or the intermediate school district. Parent/caregivers will often consult with a speech-language pathologist to decide whether a concern warrants further evaluation. Sometimes parent concerns are the result of a lack of understanding about the variances that occur in typically developing language proficiency. Therefore, a developmental screening using the *Ages and Stages Questionnaires* (ASQ) should be completed in addition to an informal interview to obtain the parent's concerns to determine if the child's communicative behaviors are within the scope of typical behavior or if a comprehensive evaluation is warranted. If a formal evaluation is not necessary at the time of concern, speech-language pathologists may provide suggestions to be carried out at home or in the classroom to facilitate the continuation of language development.

If it is determined that the child needs to have a formal special education speech and language assessment, then a notification letter needs to be provided to the parents and the *REED* needs to be secured before the assessment can begin.

**Conducting the Speech and Language Assessment**—A worksheet in the *Optional Tools* section of these guidelines, the *Preschool Language Eligibility Guide/Team Summary*, provides a guide for the formal assessment. The assessment section is organized by this table, as each row in the summary guide is a heading in the text. This is followed by an explanation of suggested assessment activities.

**Gather Input**—As with any assessment of a young child, it is important to obtain a complete developmental and health history as well as obtain information about any family members with a history of hearing or communicative disorders. Input from preschool teachers, daycare providers or other people that spend time with the child may be beneficial.

### **Play Activities and Communication Samples:**

**Observing Language Subsystems**—Gathering and forming impressions regarding samples of the preschooler's oral language is another essential component of the evaluation. An oral language sample can provide the speech-language pathologist with information regarding the preschooler's language

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subsystems, frustration when communicating, and communication when scaffolding is provided. The speech-language pathologist usually plays with the child for 10 to 15 minutes using developmentally appropriate toys. During a play-based activity, the speech-language pathologist should take notes about all of the language subsystems (such as: phonology, syntax, morphology, semantics, and pragmatics).

When evaluating phonology skills, the speech language pathologist is noting the level of intelligibility as well as phonemes/speech sounds that the child can and cannot produce.

In regards to syntax, the speech-language pathologist determines the preschooler's mean length of utterance and complexity of the utterance. Morphological markers are another subsystem of interest (see the *Optional Tools* section for more information).

Observation of the child's semantics can provide the speech-language pathologist with the types of words the child is using (such as, nouns, verbs, prepositions).

It is just as important to collect information regarding pragmatic language including the ways the child communicates (such as, crying, pointing, intonation) and the functions the attempts serve (to request, protest, greet, name, and comment). For some children, the goal is to determine whether the preschooler has intent to communicate. If intent is demonstrated, the speech-language pathologist should question how the preschooler communicates. If intent is not demonstrated, it is important to provide the preschooler with opportunities to protest, request, and name objects during play.

**Evidence of Communicative Frustration**—Play-based assessments can also give the speech-language pathologist information regarding the preschooler's frustration level when trying to communicate. This can be a determining factor when qualifying a preschooler of this age for speech and language services.

**Utilizing Dynamic Assessment**—The speech-language pathologist should provide support and accommodations to the preschooler to see if communication functioning improves. Often, communication improves with scaffolding, when picture symbols are introduced, or when language is made simpler and less complex. During this time, the speech-language pathologist documents if the preschooler's language improved with such interventions or if the preschooler continued to have difficulty. Observing how the preschooler reacts to these scenarios is beneficial when treatment planning.

**Formal assessment**—Standardized testing is required when evaluating any child's speech and language skills. It is important to be familiar with author's guidelines for in-

interpretation of test scores and to look for variations within the child's language profile that may suggest deficits within a language subsystem which should be explored further. Commonly used tests standardized for the preschool population have been included in the appropriate areas of this document.

**Observation of Parent-Preschooler Interactions**—Many children display more or less language when they are with familiar people such as their parents/caregivers or siblings. Familiar people in familiar surroundings typically offer the ideal scenario to obtain a picture of a child's functional level of communication. Observation of parent-child interactions can allow the SLP to explore what kind of communicator the child is and what kind of role the parent assumes in the communicative interaction. Speech-language pathologists can observe parent-child interactions when the child is coming to and from the therapy room. They can also be observed by providing 10 to 15 minutes of play between the child and parent or by making a visit to the home if necessary. This part of the assessment helps the speech-language pathologist to make effective suggestions for a home intervention plan.

**Consideration of Cultural/Linguistic Differences**—Children ages 3-5 may enter preschool from a monolingual perspective, that is only being exposed to their native language; or from a simultaneous bilingual environment where they were exposed to two languages simultaneously, before one language is well established; or from a sequential bilingual background where they are being exposed to a second language after the first is well established. It is important to determine the dominant language of the child prior to an evaluation. If the child is from a bilingual home then they should be assessed in both languages to determine dominance. If the child acquires two languages simultaneously, the stages of development are the same as they are for monolingual speakers of those languages. A child growing up with two or more languages is often slower to meet these developmental stages than a monolingual child. Following an evaluation, an SLP must determine if the child is showing a language delay or a language difference due to learning more than one language. If the child's skills are within normal limits in the native language, second language delays cannot be considered a disorder. If the child demonstrates a speech and language delay in their native language then they may be considered for eligibility for special education services. If this is the case, it is permissible for the student's goals and treatment to be provided in English. Refer to the English language learners section and the Birth to Three section for more information when considering eligibility for a child whose native language is not English.

**Eligibility Considerations**—The primary goals of the initial assessment are to determine eligibility and to identify an appropriate treatment plan. This means that the speech language pathologist and team must determine:

- Whether a speech and language impairment exists,
- Whether the speech and language impairment adversely affects the child's ability to progress in age appropriate activities and/or the general curriculum (academic, nonacademic, or extracurricular), **—and—**

- In absence of cultural/linguistic and/or environmental/economic differences.

**Providing Services to the Preschool Population**—Services to the preschool population are provided by the local school district. These services can vary greatly depending on the types of programs available in that community. The preschool population should be afforded the same Least Restrictive Environment (LRD) considerations as the school-age population. The continuum of services ranges from placement in an Early Childhood Special Education (ECSE) Program, services provided within a preschool program (private/GSRP/Head Start), to individual therapy where the child is brought into the school on a schedule determined between the parent and speech and language therapist. The individual child's present level of functioning, severity of speech and language disorder, communication needs and response to scaffolding techniques should all be considered when determining an appropriate service delivery model. Collaboration between the speech-language pathologist and community preschool programs is recommended to insure a full continuum of options.

Regardless of the setting in which a child receives services, all preschool age children shall have an IEP in order to obtain their special education services.

**Response to Intervention**—A response to intervention (RtI) model may be considered for some preschool age children. If this is the case, the team must make a formal plan for early intervening services (refer to the *Language* section for the form and instructions). It is recommended that this model only be considered for preschool age children that have a general education setting (some type of preschool program) in which to implement the plan. There is a specific early intervening program designed for preschool called *Recognition and Response* ([www.recognitionandresponse.org](http://www.recognitionandresponse.org)). This should be explored further if a complete RtI program is considered at a preschool level.

## Secondary

**Assessment Considerations for Adolescents**—Initial identification of an adolescent with a language impairment is rare at the secondary level and often involves a teacher or parent referral (Larson & McKinley, 2003).

1. It is recommended that the referral follow the ICISD *Screening to Evaluation Flowchart*. Make sure that appropriate intervention procedures have been tried and documented. The SLP and/or other professional staff involved in the evaluation procedure should review the comprehensive educational history from the cumulative file to explore patterns in the student's education that correspond to the initial concern.
2. During this phase, the speech-language pathologist should carefully consider the impact of teacher presentation style and classroom routines in a variety of the student's scheduled classes as they relate to language (Larson & McKinley, 2003). The speech-language pathologist should explore these areas further when gathering information about the student's language problems and determine if the communication breakdown occurs in the student's

comprehension of the message or the teacher's presentation of the material. This information may also be useful when recommending classroom accommodations and modifications.

3. Following appropriate screening and observations, accumulated curriculum-based language assessment, dynamic assessment, language samples and portfolio reviews may provide useful information about the student's language abilities.
4. Standardized testing should be used as part of the initial speech and language assessment to determine receptive or expressive language deficits.

**Assessment Considerations for Redetermination**—Students who are being reevaluated for SLI eligibility may fall into several categories listed below. The REED will drive the evaluation requirements.

1. Students who may have shown a consistent speech and language impairment through at least two comprehensive evaluations, indicating a pervasive speech and language impairment throughout their educational experience may require a review of past MET findings, input from staff and parents, and a careful examination of present level of functioning within the curriculum. Formal standardized testing **may not** be required to define the eligibility due to consistent patterns over a number of evaluations. If so, a report reflecting previous MET reports, staff input and educational implications is sufficient.
2. Students may have demonstrated increased language skills in their pragmatic, semantic or syntactical skills, either through documented observation or through improvement within the curriculum. This progress may have positively impacted academics indicating a possible reduction of services or elimination of the SLI eligibility. In that instance, it would be advisable to conduct formal standardized testing to assess growth, as well as the other information gathered from involved staff, to help determine eligibility status.
3. Students may have dual labels of eligibility at the secondary level, such as a primary eligibility as learning disabled, autism spectrum disorder, or cognitive impairment, with a secondary eligibility of SLI. At this juncture in special education services, it may be appropriate to assess if the resulting and lingering language difficulties are a residual effect of the primary learning difficulty (learning disability, autism spectrum disorder or cognitive impairment) or if there is a specific speech and language disability. **This determination should seriously be considered by the evaluation team, who will then decide if the secondary eligibility of SLI remains appropriate and necessary. Regardless, the duplication of services between the special education teacher and speech-language pathologist should be assessed.** If services pertinent to the language deficit are being delivered in the special education classroom, consultation or monitoring by the speech-language pathologist may be considered more appropriate for that student at this stage in his/her education.

**Intervention Consideration for Adolescents**—As with any student diagnosed with a

language impairment, intervention planning should be curriculum-based and goals should emphasize a strategies-based type of intervention rather than instruction of discrete skills. Therefore, it may be more appropriate for the speech-language pathologist to collaborate with the teacher on implementing strategies in the classroom everyday, rather than employing direct or duplicate instruction. The speech-language pathologist may monitor the student's use of strategies through the teacher's reporting on classroom instruction and performance.

**Service Delivery Considerations for Adolescents**—Service delivery models should reflect the type of intervention needed for the student based on the IEP. Wallach and Butler (1994) caution against “importing” traditional elementary pull-out models to the secondary level. Consultation or monitoring are important service delivery options in any secondary setting. It is essential that the speech-language pathologist schedule time for collaborating with other school professionals to discuss language instruction needs and monitoring of student progress, as well as development of materials.

Adolescent language development should be contextually-based so increasing language development is accomplished through the special education classroom learning opportunities. Language is learned in a pragmatic, experiential manner and can be expanded and reinforced throughout the student's program. Consultation with staff concerning student's needs and appropriate language skills may occur periodically or as requested. The choice of monitoring student progress or consulting with the student, including working on defined goals, are viable service delivery options.

**Students who are placed in categorical special education classrooms should receive embedded language instruction through their curriculum, and may not require continued direct speech-language pathologist services. Resources and language enrichment lessons can be provided to teaching staff. The more that speech-language pathologist services are integrated into the student's daily routine and academic curriculum, the more effective learning will be. Direct service to adolescent-aged students should be limited to skills that can only be delivered through specialized therapy techniques provided by a speech-language pathologist.**

Students in a resource room program are usually provided teacher instruction related to vocabulary. Understanding terms within the curriculum is more directly tied to their educational program. Instruction in this area may include vocabulary reinforcement through study guides or various modalities of learning, test-taking strategies, learning memorization techniques, visualizing and verbalizing information, resources to draw on, and so on. The speech-language pathologist is available in a consultative role if specific problems arise. If there are pragmatic communication issues that are interfering during this stage of adolescence, then a more direct speech and language intervention may be appropriate.

For students who qualify as SLI only, direct services may be indicated for fluency,

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voice, or articulation difficulties. The intensity and determination of service will be dependent on the student's need for improvement, level of sustained progress, priority of service within the student's academic requirements, and support of involved evaluation team members, parents, staff, student, and speech-language pathologist.

### **Test Recommendations for Adolescents**

- *Clinical Evaluation of Language Fundamentals–4 CELF-4*
- *Test of Adolescent Language–R TOAL*
- *Test of Language Competency TLC*
- *Comprehensive Assessment of Spoken Language CASL*

## English Language Learners

English Language Learners (ELL) is the term used in this document to refer to students who need special considerations due to cultural and/or linguistic differences. ELL is also the term adopted by the State of Michigan for use in reference to all students who are limited English proficient (LEP). MSHA Guidelines (2006) refer to these students as “culturally and linguistically diverse populations” and include this information in three sections: CLD-I, CLD-L, and CLD-A.

English language learners do not qualify for special education simply because of their limited English language or articulation. As a matter of fact Federal law §300.306 (IDEA, 2004) specifically states that the student’s communication difficulties must not be due to limited English proficiency.

ELL students are entitled to considerations under other federal and state requirements (34 CFR Part 100). If a district has enough ELL students to warrant having its own ELL coordinator, he/she would be the first person to consult for information and assistance. For more information on what you need to know before assessing an ELL child for special education, review the article, *A Summary of English Language Learners with Special Education Needs* located at <http://tinyurl.com/ELL-SpecEd>.

Anyone working with the ELL population should be familiar with the typical natural second language acquisition process. Acquisition of a second language can look like a SLI, but in fact is not. Typical stages include:

1. **Silent Period**—The student is focusing on comprehension of English. Lasting up to a year after initial exposure, this period is marked by responses to English which are non-verbal or limited to one or two words. Progress can be interrupted or slowed down if the student is required to perform too early in the acquisition process.
2. **Language Loss**—First language skills diminish from lack of use. This often occurs when students spend more time in all English-speaking classrooms. This is a transition period and can look like a SLI.
3. **Reduced Exposure**—Poor performance in either language may result from limited exposure to a rich vocabulary. This may result from someone else speaking for the student, poor attendance, or other factors. Underlying conceptual development may be underdeveloped due to reduced learning opportunities.
4. **Code-switching**—The student changes from one language to another in the same sentence or paragraph.
5. **Inter-language**—A temporary language system which fluctuates as the student tests hypotheses about language and modifies rules as a result of these trials. The student is integrating aspects of both languages.

6. **Interference**—As the student becomes more fluent in English, aspects of the first language such as syntax may occur when using English.
7. **Fossilization**—The student achieves good fluency in English, but continues to make certain specific mistakes in structure or vocabulary (such as endings left off or pronoun confusion).

Keep in mind the typical natural second language acquisition process when looking for indicators of a noncultural or language based disability. Differences in sentence structure, speech sound production, vocabulary, and the pragmatic uses of language are to be expected when learning a new language. A student may have difficulty learning because of a lack of exposure to English language or because of cultural experiences that are not commensurate with the school's expectations.

Two levels of language proficiency are identified by Cummins (1992). The first is basic interpersonal communication skills (BICS) which refers to language learned and used when there are clues to aid in comprehension. The second level is cognitive academic language proficiency (CALP) which refers to language used in academic learning with few clues and generally involve abstract concepts. A student needs both BICS and CALP to be successful academically.

Possible indicators of a noncultural or language based disability in students who are ELL include (Kayser, 1998; MSHA, 2006; Roseberry-McKibbin, 2002):

- Short mean length of utterance (MLU);
- Difficulties affecting grammar and sentence structure;
- Difficulty in learning language at a normal rate, even with special assistance in both languages;
- Slow academic achievement despite adequate academic English proficiency;
- Communication difficulties at home;
- Communication difficulties when interacting with peers from a similar background;
- Inappropriate responses when peers initiate interaction;
- Difficulty being understood by peers;
- Overall communication skills which are substantially poorer than those of peers;
- Frequent inappropriate responses;
- Failure to express basic needs adequately;
- Communication that is disorganized, incoherent, and leaves the listener confused;
- Speech and/or language difficulties generally evident in both English and the primary language;
- See MSHA Guidelines pages CLC-L11 to L12; CLD-A-8 to 10 for a list of phonological and language features in dialects and languages in the United States.

Preventative, research-based early intervention is essential in working with ELL students. Scaffolding support for instruction and a dynamic assessment approach (test-teach-retest) works very well. ELL students benefit more from this process than many other students and the information gained is an essential part of determining if the student is speech or language impaired. The student's rate of learning over time under ideal conditions (research-based interventions) is invaluable in separating cultural or linguistic differences from a special education speech or language impairment. When the speech-language pathologist works under the workload versus caseload approach (outlined earlier in this document) he/she could be very helpful with the early intervention team's efforts. Trial intervention may be beneficial in helping to determine the student's overall language abilities in both English and their native language. Screening during trial intervention may require the assistance of an interpreter.

School districts have different resources and personnel of varying skill levels to work with English language learners.

Print resources include:

- Assessment and Intervention Resource for Hispanic Children (Kayser, H., 1998). Although written with a Hispanic focus, much of this applies to students with other cultural and linguistic differences.
- Cultural and Linguistic Diversity Resource Guide for Speech-Language Pathologists (Goldstein, B., 2002). A practical and easy to use book that "...bridges the gap between existing research and the use of that information in ...practice..." (p. xii).
- Differentiated Literacy Instruction for English Language Learners (Quiocho, A. L. & Ulanoff, S. H., 2009). Focuses on initial assessment and interventions for literacy instruction in English language development; also contains information on assisting ELL students who have been qualified for special education services.
- Multicultural Students with Special Language Needs-Second Edition (Rosberry-McKibben, 2002). An excellent resource for intervention and assessment strategies for working with students who come from a wide range of diverse cultural and linguistic backgrounds.
- Special Education Considerations for English Language Learners: Delivering a Continuum of Services (Hamayan, E., Marler, B., Sanchez-Lopez, C., & Damico, J., 2007). Discusses interventions to be utilized before, during, and after special education qualification as well as continuing integration of English language development.
- Teaching English Language Learners: A Differentiated Approach (Rothenberg & Fisher, 2007). Contains very specific strategies and activities for the practitioner.

Web-based resources as of July 2010 include:

- Colorin Colorado ([www.colorincolorado.com](http://www.colorincolorado.com)) has Latino focus but also offers literacy and school tip sheets for parents in several languages.

- Kent ISD is a good source for ELL information (<http://tinyurl.com/Kent-ISD-ELL>)
- Kent District Library ([www.kdl.org](http://www.kdl.org)). Resources are available in the Play, Grow and Learn area including developmental activities for early literacy and reading tips in eight languages.
- National Clearinghouse for English Language Acquisition and Language Instruction Educational Programs ([www.ncele.gwu.edu](http://www.ncele.gwu.edu)) "...collects, analyzes, synthesizes and disseminates information about language instruction educational programs for English language learners and related programs." It is funded by the U.S. Department of Education under Title III of the No Child Left Behind (NCLB) Act of 2001.

Evaluating ELL students for special education as speech-language impaired or under any other category is complex. The goal of an evaluation is to determine if a student is SLI after any cultural or linguistic differences have been factored out.

After following the above procedures, if it is determined that a special education evaluation is appropriate, the same requirements under IDEA §300.304 for any other evaluation apply. However, special considerations need to be given to:

1. The cultural competence of the speech-language pathologist (MSHA, 2006, p. CLD-I-1) and others working with the student.
2. The use of interpreters throughout the process (MSHA, 2006, pp. CLD-I-2 & 3).
3. A comparison of any tests used with the Standards for Educational and Psychological Testing (AERA, APA, NCME, 1999) Chapter 9 "Testing Individuals of Diverse Linguistic Backgrounds". These standards include:
  - The student's language proficiency in both English and primary language,
  - Validity and reliability of the test for this specific individual,
  - Use of interpreters (pp. 95-96).
4. MSHA Guidelines (2006) emphasize when using "...an English standardized assessment tool with an interpreter or any other adaptations of the procedures, then the standardized score(s) cannot be used to make eligibility decisions." (p. CLD-I-3).
5. Any test used for determining eligibility should also be evaluated for use according to the prior Critical Issues section on the use of standardized tests.
6. At this time there are probably no "good" tests for determining eligibility for this population.
7. Additional requirements for an evaluation §300.304 (IDEA, 2004) take on a vital role in determining special education eligibility. More time and importance needs to be given to areas such as parent input, observations, review of existing data, results of research-based interventions, trial intervention, and other related data.

It is recommended that the *"Culturally and Linguistically Diverse Guide/Team Sum-*

mary” from the *MSHA Guidelines 2006* be used by the team. Obtaining parent information for this population necessitates establishing a rapport and ongoing working relationship over time. The question of how this child performs relative to other children in the family should be asked and the information utilized by the evaluator. Although this is not legally required, best practice in Ionia County ISD has shown that the student is a valuable source of information and his/her input should be solicited and utilized in the evaluation process. An informed clinical opinion as discussed in the *Evaluation* section of this document necessitates that any and all relevant information be considered in making a special education eligibility determination.

**The SLP’s Role in Absence of an ESL Program (ASHA)**—In the absence of an ESL program, the speech-language pathologist should provide ESL instruction only if they have the required knowledge and skills. In the absence of this knowledge and skill, the speech-language pathologist should:

1. act as a consultant to the child's primary caregivers, classroom teacher, and other professionals; and
2. advocate for the child to professionals and other agencies (<http://tinyurl.com/SLP-Role-Absence-of-ESL-Prog>)

In summary, English language learners are a difficult and complex population with whom to work and to evaluate for special education. Early intervention using research-based strategies should be utilized both prior to consideration for a special education referral and during the evaluation. The information obtained during early intervention can form a solid basis for a special education evaluation. For additional information see the *English Language Learners in Schools: Checklist for Educational Modifications* (<http://tinyurl.com/ASHA-org-ELL-Checklist>).

## ASSISTIVE TECHNOLOGY

The Ionia County ISD has a process for providing Assistive Technology (AT) for students with various disabilities throughout Ionia County. When a teacher, parent, and/or other staff member in the local district believes that one of their students with a disability is in need of AT, then they complete an AT Referral and send it to the AT Coordinator.

### **AT Legislation:**

The term “assistive technology device” means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve functional capabilities of children with disabilities. (IDEA, §300.5) The term “assistive technology service” represents any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device (IDEA, §300.6)

### **Who We Are:**

The Ionia County ISD Assistive Technology Coordinator collaborates with representatives from all local area districts, including all public, charter and non-public schools, on assistive technology issues in compliance with the Individuals with Disabilities Education Act (IDEA) regulations. Emphasis is placed on building district capacity and local staff skills to address student’s assistive technology needs at a local level. Our motto at the ISD regarding AT is “Putting the tools into the hands that need them.”

### **The Process:**

When the AT Coordinator receives a referral, he meets with the team of individuals who work with this student to get a better picture of what the student’s needs are (“Screening Meeting”). The team may include the teacher, parent, therapists, etc.— basically anyone who works with this student is invited. After meeting, depending on what concerns were discussed, the AT Coordinator may make some recommendations for what type of AT to try. The team may include the teacher, parent, therapists, etc.— basically anyone who works with this student is invited. After meeting, depending on what concerns were discussed, the AT Coordinator may make some recommendations for what type of AT to try.

### **How to Get Help:**

- The AT Referral is available on the Ionia ISD website ([www.ioniaisd.org](http://www.ioniaisd.org)) under “Special Education—Resources.”
- Contact the ISD AT Coordinator: 616-527-4900

## GLOSSARY

- Apraxia** – Impaired ability to generate the motor programming for speech movements. It is a planning/programming problem resulting from a central nervous system lesion.
- Articulation** – A speech disorder that affects the phonetic level; difficulty saying particular consonant and vowel sounds.
- Assessment** – The orderly process of gathering, analyzing, interpreting, and reporting student performance from multiple sources over a period of time.
- Auditory Processing** – Auditory processing is a term used to describe recognition and interpretation of sounds. Hearing occurs when sound travels through the ear and is changed into electrical information that can be interpreted by the brain. An auditory processing disorder means that something is adversely affecting the processing or interpretation of auditory information.
- Basic Interpersonal Communication Skills (BICS)** – Face-to-face conversational fluency, including mastery of pronunciation, vocabulary, and grammar.
- Blocks** – Inappropriate cessation of sound and air, often associated with freezing of the movement of the tongue, lips and/or vocal folds. Blocks often develop later, and can be associated with muscle tension and effort.
- Cluster Reduction** – The deletion through the lips or tongue; tight closure in the larynx (voice box); forceful repetitions or prolongation of sounds, usually at the beginning of words; difficulty in making voiced sounds (phonation); and/or silent blocks, in which no sound comes out at all on one or more consonants from a two or three consonant cluster.
- Cluttering** – A disorder of speech and language processing resulting in rapid, dysrhythmic, sporadic, unorganized, and frequently unintelligible speech. Accelerated speech is not always present, but cluttering is frequently accompanied by an impairment in formulating language.
- Cognitive/Academic Language Proficiency (CALP)** – Language proficiency associated with schooling, and the abstract language abilities required for academic work.
- Code-switching** – Moving from one language to another, inside a sentence or across sentences.
- Culture** – The customs, lifestyle, traditions, behavior, attitudes, and artifacts of a given people.
- Diadochokinetic** – Refers to the rapid production of alternating sounds. Diadochokinetic rate (DDK) refers to an assessment tool, that measures how quickly an individual can accurately produce a series of rapid, alternating sounds (tokens); may be one syllable such as "puh," two or three syllables such as "puh-tuh" or "puh-tuh-kuh," or familiar words such as "pattycake" or "buttercup." Other names for DDK rate include maximum repetition rate.
- Dialect** – The form of a language peculiar to a specific region; features a variation in vocabulary, grammar, and pronunciation.
- Diplophonia** – the production by the voice of two separate tones through abnormal variations in the vocal fold vibration.

## Glossary

- Disfluency** – (stuttering) is an abnormally high frequency or duration of stoppages in the forward flow of speech. See **Blocking**.
- Dysarthria** – Speech disorders that result from the disruption of muscular control due to lesions of either the central or peripheral nervous systems. It is classified as a neuromotor disorder.
- Early Childhood Developmental Delay (ECDD)** – A primary delay in a child through 7 years of age that cannot be differentiated through existing criteria for any other impairment, manifested by a delay in 1 or more areas of development equal to or greater than half of the expected development.
- English Language Learner (ELL)** – Children and adults who are learning English as a second or additional language; applies to learners across various levels of proficiency in English.
- Evaluation** – Judgments about students' learning made by interpretation and analysis of assessment data.
- Expressive Language** – For Speech-Language, the production of language to convey meaning to others. See **Receptive Language**.
- Final Consonant Deletion** – The deletion of the final consonant or consonant cluster in a syllable or word.
- Fluency Disorder** – An interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllable words, and phrases. This may be accompanied by excessive tension, struggles with behavior, and secondary mannerisms.
- Fronting** – The substitution of sounds in the front of the mouth.
- Hypernasality** – Too much resonance in the nasal cavity.
- Hyponasality** – Too little resonance in the nasal cavity which may sound similar to the speech of someone experiencing a head cold.
- Limited English Proficient (LEP)** – Refers to students with restricted understanding or use of written and spoken English.
- Mean Length of Utterances (MLU)** – Calculated by collecting 100 utterances spoken by a child and dividing the number of morphemes by the number of utterances. A higher MLU is taken to indicate a higher level of language proficiency.
- Measurement Error** – The difference between an observed score and the corresponding true score.
- Morphology** – The study of morphemes, which is the smallest linguistic unit that has semantic meaning. In spoken language, morphemes are composed of phonemes, the smallest linguistically distinctive units of sound. See **Phonology**.
- Multilingualism** – The ability to speak more than two languages; proficiency in more than two languages.
- Native Language** – An individual's first, primary, or home language.
- Non-English Speaking (NES)** – Individuals who are in an English-speaking environment but who have not acquired any English proficiency.
- Normative Sample** – A selection of a specified number of test takers from a larger population on which statistical data that summarize the test performance are determined.
- Oral-motor** – Refers to physical functioning and coordination related to the physiological production of speech.

## Glossary

- Phonemic Awareness** – The ability to hear and manipulate the sounds in words.
- Phonetics** – Organizing speech sounds into patterns of sound contrasts to create words.
- Phonology** – The study of phonemes, the smallest linguistically distinctive units of sound. See **Morphology**.
- Prevocalic Voicing** – The voicing of an initial voiceless consonant in a word.
- Prelinguistics** – The developmental stage of natural expression in newborn to young children that includes crying, cooing, babbling, and intonation; prior to intentional use of phonemes for initial word formation.
- Pragmatics** – The area of language function as it is used in social contexts.
- Receptive Language** – For Speech-Language, the discrimination, interpretation, and comprehension of meaning from received sounds produced by sources external to the listener. See **Expressive Language**.
- Resonance Disorder** – Disorders of speech sound quality, often characterized by physiological anomalies, such as hyper/hyponasality, nasal air escape, or malformed/malfunctioning functioning palate. Distinguished from **Voice** disorders caused by the actual production of speech in the larynx.
- Scaffolding** – Building on a person's existing repertoire of knowledge and understanding. Adult support for learning and student performance of the tasks through instruction, modeling, questioning, feedback, graphic organizers, or other techniques across successive meetings. These supports are gradually withdrawn.
- Semantics** – The aspect of language function that relates to understanding the meanings of words, phrases and sentences.
- Standard Deviation (SD)** – In statistics, a measure of how data points in a set (presumed to be distributed in a bell curve) are distributed around the mean. A low standard deviation means that the data are tightly clustered around the mean; a high standard deviation means scores are more scattered. Many tests use a scoring scale with mean of 100 and standard deviation of 15, meaning that about 68% of all scores across a broad sample will fall within +1 or -1 standard deviations (a score of 85 to 115).
- Stopping** – The substitution of a stop consonant for a fricative or affricate.
- Stuttering** – (Disfluency) is an abnormally high frequency or duration of stoppages in the forward flow of speech.
- Subtractive Bilingualism** – The learning of a new language at the expense of the primary language.
- Syllable Reduction** – The deletion of a syllable from a word containing two or more syllables.
- Syntax** – The structural sequence of language.
- Transdisciplinary Approach** – Professionals from different disciplines work together, with one of them serving as the primary contact with the family. The primary contact uses strategies that the other team members provide; the other team members have direct contact with the child and family only as necessary.
- Reliability** – The degree to which test scores for a group of test takers are consistent over repeated applications of a measurement procedure; the degree to which

## Glossary

scores are free of errors of measurement for a given group.

**Specificity** – The degree to which a test accurately identifies speech-language impaired as speech-language impaired.

**Sensitivity** – The degree to which a test accurately identifies non-speech-language impaired as non-speech-language impaired.

**Validity** – The degree to which a test measures what it purports to measure; evidence that inferences from the evaluation are trustworthy.

**Vocal Nodules** – Added layers of tissue on the vibrating edge of the vocal folds that vary in size from pinpoint to the size of a peppercorn. They develop as the body attempts to protect itself against abuse and overuse of the voice.

**Voice Disorder** – Disorders caused by dysfunction of the larynx in the actual production of speech. Distinguished from sound quality **Resonance** disorders caused by other structural/functional issues.

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## **Appendix A**

### **Section 504 vs. IDEA**

Section 504 is a federal civil rights law designed to protect the rights of individuals with disabilities in programs and activities that receive federal funds from the U.S. Department of Education. Section 504 requires recipients to provide to students with disabilities appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met.

Section 504 is intended to establish a “level playing field” usually by eliminating barriers that exclude persons with disabilities.

To be qualified under section 504, a student must be determined to:

1. have a physical or mental impairment that substantially limits one or more major life activities;
2. have a record of such an impairment; **or**
3. be regarded as having such an impairment.

IDEA is a federal funding statute whose purpose is to provide financial aid to states in their efforts to ensure adequate and appropriate services for disabled children.

IDEA identifies specific categories of qualifying conditions. A student is only eligible to receive IDEA services if the multidisciplinary team determines that the student is disabled under one of the qualifying conditions and requires special education.

“Appropriate education” means a program designed to provide “educational benefit.”

IDEA often requires the provision of programs and services in addition to those available to persons without disabilities. It requires a written and specific IEP document.

The definition of a disability under Section 504 is much broader than the definition under IDEA. All IDEA students are also covered by Section 504, but not all Section 504 students are eligible for services under IDEA.

## **Appendices**

**INSERT APPENDIX B: ISD REQUEST FOR SCREENING HERE**

## Appendices

### **INSERT APPENDIX C: Notification of S-L Screening**

## Appendices

### **INSERT APPENDIX D: Screening to Evaluation Flowchart**

## Appendices

### **INSERT APPENDIX E: Prior written notice of initial referral**

## Appendices

**INSERT APPENDIX F: REED (1 of 2 pages)**

## Appendices

**INSERT APPENDIX F: REED (2 of 2 pages)**

## Appendices

**INSERT APPENDIX G: Timeline for Spec Ed Evaluation  
flowchart here**

## Appendices

**INSERT APPENDIX H: SLI MET**

## Appendices

**INSERT APPENDIX I: SLI19-SLI-10 Dismissal Criteria from MSHA Guidelines here (1 of 2 pages)**

## **Appendices**

**INSERT APPENDIX I: SLI19-SLI-10 Dismissal Criteria from  
MSHA Guidelines here (2 of 2 pages)**

## Appendices

**INSERT APPENDIX J: ENTs in Ionia (1 of 2 pages)**

## Appendices

**INSERT APPENDIX J: ENTs in Ionia (2 of 2 pages)**

## Appendices

**INSERT APPENDIX K: Delay Based on Chronological Age vs Performance Age Table here (1 of 2 pages)**

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# INSERT: File#1, Articulation Eligibility

INSERT IOWA/NEBRASKA  
NORMS HERE

INSERT files 3-12

# Interpretation of Test Scores (under construction...to be inserted at a later date)

Insert Files 13-16 here

## **Speech-Language Assessments Utilized in Ionia County**

### **Articulation**

- Structured Photographic Articulation Test II (SPAT-D)
- Clinical Assessment of Articulation and Phonology (CAAP)
- Goldman Fristoe 2
- Khan-Lewis Phonological Analysis
- Kaufman Speech Praxis Test
- Photo Articulation Test (PAT)

### **Vocabulary**

- Expressive One-Word Picture Vocabulary Test (EOWPVT)
- Receptive One-Word Picture Vocabulary Test (ROWPVT)
- Peabody Picture Vocabulary Test 3<sup>rd</sup> Edition (PPVT-III)
- Expressive Vocabulary Test (EVT)
- Comprehensive Receptive and Expressive Vocabulary Test, Revised (CREVT)
- The Word Test 2 (Elementary)
- The Word Test (Adolescent)
- Boehm Test of Basic Concepts, Third Edition (Boehm-3)
- Test of Word Knowledge (TOWK)
- Test of Semantic Skills-Intermediate (TOSS-I)

### **Language**

- Structured Photographic Expressive Language Test, Third Edition (SPELT-2)
- Structured Photographic Expressive Language Test, Preschool (SPELT-P)
- Rosetti Infant Toddler Scale
- Preschool Language Scale, Fourth Edition (PLS-4)
- Clinical Evaluation of Language Fundamentals-Preschool, Second Edition (CELF-P 2)
- Clinical Evaluation of Language Fundamentals, Fourth Edition (CELF-4)
- Comprehensive Assessment of Spoken Language (CASL)
- Test of Language Development Primary, Third Edition (TOLD P:3)
- Test of Language Development-Intermediate, Third Edition (TOLD-I:3)
- Test of Auditory Comprehension of Language, Third Edition (TACL 3)
- Test of Auditory Processing of Language, Third Edition (TAPS 3)
- Language Processing Test, Revised (LPT-R)
- Test of Problem Solving-Elementary, Second Edition (TOPS:2)
- Test of Pragmatic Language (TOPL)
- Functional Communication Profile
- Token Test
- The Listening Comprehension Test, Second Edition
- The Listening Test-Adolescent
- Evaluating Acquired Skills in Communication, Revised (EASIC R)

(continued on next page)

# Speech-Language Assessments Utilized in Ionia County

## Language (continued)

- The Non-Speech Test
- Test of Word Finding, Second Edition (TOWF 2)

## Stuttering

- Stuttering Severity Instrument, Fourth Edition (SSI 4)

Insert files 17-23 here

## **Commonly Used Standardized Assessments for the Infant/Toddler Population**

### **Global Language Instruments**

- *Preschool Language Scale 4th Edition (PLS-4)*
- *Preschool Language Scale Spanish – 4th Edition*
- *Receptive Expressive Emergent Language Test 3rd Edition (REEL-3)*

### **Expressive Language Instruments**

- *Expressive One Word Picture Vocabulary Test (EOWPT)*

### **Receptive Language Instruments**

- *Peabody Picture Vocabulary Test (PPVT-4)*

### **Articulation Instruments**

- *Goldman-Fristoe Test of Articulation (GFTA-2)*

### **Other Assessment Tools Helpful in Evaluation of Infant/Toddlers**

- *Rossetti Infant Toddler Language Scale*—criterion reference tool results reported as a percentage of items passed at a particular age level
- *Hawaii Curriculum*—Criterion reference tool; results reported as a percentage of items passed at a particular age level
- *Evaluating Acquired Skills In Communication (EASIC)*—Criterion reference tool; useful to inventory and describe behaviors particularly prelinguistic and social-communication aspects.
- *MacArthur-Bates Communicative Development Inventory (CDI)*
- *Communication & Symbolic Behavior Scale Checklist*

Insert files 24-38 here

## STRATEGIES to IMPROVE AUDITORY PERFORMANCE

### Strategies for Teachers

#### **Classroom Environment**

- Reduction of noise/minimize distractions
- Preferential seating away from noise
- Use of classroom amplification system

#### **Teaching Techniques**

- Clear enunciation at a slow-moderate rate of speech
- Insert purposeful pauses between concept, let the words hang in the air
- Keep directions or commands short and simple and have student repeat directions
- Use praise often and be positive
- Provide visual cues during lecture/directions (such as written outline on the board)
- Provide repetition of oral information and steps of assignment
- Give breaks between intense concepts taught for comprehension
- Check for comprehension early/often and check knowledge of prerequisite information
- Preview and review concepts for lecture
- Offer short essay tests as an alternative to multiple choice
- Record lectures for repeated listening
- Offer closed captioning for videos
- Make connections with other material whenever possible – refer often to previous lessons
- Augment information, especially with visual materials (show a film; look on web; find additional books about topic; act it out; recommend family activity; fieldtrip)

#### **Peer Assistance**

- Use a positive peer partner for comprehension of directions or proofing work
- Use cooperative learning groups
- Use a note-taker

#### **Assignment Modifications**

- Allow extended time to complete assignments and/or tests
- Offer short essays as an alternative to multiple choice
- Provide visual instructions
- Preview language of concept prior to assignment
- Checks frequently for comprehension at pre-determined points
- Vary grading techniques

### Strategies for Student

- Teach use of visual cues to supplement auditory information
- Teach use of short- and long-term memory techniques (i.e. rehearsal,

chunking, mnemonics, visual imagery)

- Teach student to listen for meaning rather than every word
- Teach active listening behaviors
- Teach student to advocate for themselves by asking frequent questions about the material, asking for multiple repetitions or requesting speaker to “write it down”
- Use of tape recorder for assignments
- Teach organizational strategies for learning information
- Teach use of an electronic note-taker or word processor
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### **Strategies for Parents**

- Keep directions or commands short and simple
- Use praise often and be positive
- Use visuals or gestures at home to compensate for listening difficulties
- Assist the student in asking clarification questions and being their own advocate
- Preview and review classroom material and review tape recorded information

# Insert Files 39-50 here